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ABSTRACT

This volume is designed to provide corrections practitioners with basic staff training on the needs of those with mental illness and impairments in our correctional systems. Chapter titles are: (1) "Mental Illness in the Correctional Setting"; (2) "Substance Use Disorders"; (3) "Problems with Mood"; (4) "Problems with Thinking"; (5) "Problems with Nervousness and Fear"; (6) "Other Mental Illnesses"; (7) "The Causes of Mental Illness"; (8) "The Biological Treatments of Mental Illness"; (9) "Nonmedical Treatments of Mental Illness: Psychotherapy and Rehabilitation'; (10) "Preventing Mental Illness"; and (11) "The Inmate's Perspective: Walking in Someone Else's Shoes." A list of suggestions for further reading is included. The appendix contains four tables listing common antipsychotic, antianxiety, antidepressant, and mood stabilizing medications along with their generic and trade names, usual dosage, and major side effects. (EMK)

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Mental Health

in Corrections

An Overview for Correctional Staff

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Wesley Sowers, M.D.
Kenneth Thompson, M.D.
Stephen Mullins, M.D.

Mental Health in Corrections

An Overview for Correctional Staff

Wesley Sowers, M.D.,
and Kenneth Thompson, M.D.
with Stephen Mullins, M.D.

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Foreword

We are pleased to offer this publication on the increasingly important topic of mental health in prisons and jails. By providing proper staff training on the needs of those with mental illness and impairments in our correctional systems, we can do two important things. First, we can improve staff success in their jobs. This will lead to a greater longevity in the system and less burnout. It also should lead to increased staff safety, as staff will understand how to best handle these "difficult" inmates.

From a management perspective, a better understanding of the mental health needs of inmates will lead to fewer suicides and better classification and housing decisions. The end result will be a more smoothly functioning operation.

As corrections practitioners, we have to deal with all inmates, even those we suspect belong elsewhere. In fact, one organization, the National Alliance for the Mentally Ill/Public Citizens Health Research Group, estimates that every year, people with serious mental illnesses spend the equivalent of 11 million days in U.S. jails. Until there are better sentencing decisions, we must learn how best to deal with individuals in our system who have mental illnesses.

A recent *Focal Point: A National Bulletin on Family Support and Children's Mental Health* noted that in 1995, among Virginia's youth detention facilities, more than three-quarters of all of the youths in the state's seventeen detention facilities exhibited at least one diagnosable mental disorder, with at

least 8 percent in the severe/urgent range and 40 percent with needs in the moderate range. This is important because of the increased recidivism among those with mental illness. Many of these youth will "graduate" to adult facilities because their problems were not resolved, and they did not learn how to cope in the outside society.

This book offers suggestions on coping with substance use disorders; problems with moods, thinking, nervousness and fears; and many other mental health problems of inmates. It offers useful details and charts on the various types of medications that are available as well as their side effects.

Each chapter is well illustrated with examples that clarify the concept being discussed. The chapters on treatment of mental illness both biologically and through psychotherapy and rehabilitation offer concise suggestions about the latest thinking in these areas. Because the authors are medical doctors with extensive experience in corrections, what they write is authoritative but eminently readable. The average reader will be able to grasp the ideas presented and use the knowledge in his or job.

One important area that the book discusses is substance abuse. In addition to the information in this publication, it is important that practitioners know about other resources that can add to their professional development. ACA offers several publications on substance abuse. Another useful ACA book is *Health Care Management Issues in Corrections*, by Kenneth Faiver. It contains two chapters devoted to mental health issues. Another resource is the GAINS Center that disseminates information about substance abuse and mental illness in the criminal justice system. Practitioners may wish to get on its mailing list by contacting The GAINS Center, 262 Delaware Ave., Delmar, New York 12054, or 1-800-311-GAIN, or e-mail gains@prainc.com.

We welcome comments on this publication. If you would like to contact ACA, please call 1-800-ACA-JOIN, or e-mail us at http://www.corrections.com/aca.

James A. Gondles, Jr.
Executive Director
American Correctional Association

Introduction

"He's got an attitude!" This is a frequently heard phrase when dealing with a difficult or obnoxious person, whether in prison or jails or out on the streets in everyday life. There will be times that you will feel from the moment you meet an inmate that it is not going to be easy to tolerate him or her, and that this person will seek every opportunity to take advantage of your weaknesses. What do you do? One approach is to be tough and let this individual know who is in charge, but some inmates only will respond by pushing you even harder, even when you warn them of the consequences. Others will go to any lengths to throw you off balance, sometimes making threats that cannot be ignored, such as attempting to harm another inmate. How can they be so difficult? How can we avoid feeling angry and frustrated when dealing with people like this? When does "attitude" become a mental health problem? These are some of the questions we address in this book.

We will be talking about problems that people can develop with their mood, thinking, or ways of interacting when living in stressful, highly regimented and often-hostile settings such as jails or prisons. It has become evident both from anecdotal reports from those working in correctional facilities and from research over the past ten years that recognition of mental health problems and mental illness has become an increasingly important aspect of providing appropriate care for persons confined to jail or prison. Why is this so important? Is there any real reason that correctional officers should spend any time

trying to understand the basis of these behavioral problems? Will it be helpful to you as you go about your daily work? Most of the evidence seems to show that it can make your work more fulfilling and less stressful.

The correctional officer's main responsibilities include maintaining order and safety. Taken from this perspective, it is not difficult to see that mental illness among inmates may have a strong impact on your ability to fulfill those responsibilities.

* * *

Jose is a twenty-eight-year-old man who was recently admitted to the cell block. He appeared very reluctant to interact with other inmates from the time of his arrival, and he did not like to respond to them or the prison staff even when he was approached in a friendly manner. He seemed to be very suspicious and cautious when he was approached, as if he were about to be attacked. He seemed to prefer being alone, and often appeared to be in his own world, sometimes appearing to be watching or looking at something that was not apparent to others. As time went on, this odd behavior continued, and he seemed to become increasingly irritable, warning officers and inmates to leave him alone if they needed to ask or tell him something. Several inmates complained that he sometimes had made more serious threats when they had made accidental contact with him, and they felt that he had a strange look in his eyes, looking terrified and panicky, when he spoke to them.

One day, an inmate who was not familiar with him approached him to ask for a cigarette. As this inmate attempted to take his hand in greeting, Jose lunged at him, locking his hands around his throat and attempting to strangle him. When officers arrived to pry him loose, he became frantic, struggling with extraordinary strength to free himself. He began to scream almost incoherently that he could not be killed, that he would never tell where his family was.

He was finally subdued after inflicting injury on the inmate who approached him and two officers who were involved in restraining him. He was given some medication to decrease his agitation, and it gradually became clear that he believed that he was placed in jail as a way to put pressure on him to tell the whereabouts of his family. He felt there was a government plot to kill his family and take all their money. It turned out that, in reality, Jose came from a very poor family who still lived in the neighborhood where he grew up.

* * *

Bill was a thirty-two-year-old man who was placed in jail after being charged with the rape of his fourteen-year-old daughter. Bill was a heavy drinker and recently he had been suffering from blackouts, unable to remember anything that had happened during the period of his intoxication. When asked about this incident, he appeared very distressed and ashamed. He reported that he had come home after drinking quite heavily and that he recalled going upstairs to his bed to sleep it off, and that was the last he remembered until he woke and saw his daughter, with whom he had recently had some conflict, leaving the room saying, "I got you!" Later, he was called by his mother who told him that he had been accused of rape and that he would be arrested. As the charges were made clear to him, he became appalled and disgusted with himself, deeply ashamed and agitated by the thought that he may have done such a thing.

Bill was placed in the general population in a cell with another inmate. He was very withdrawn and continued to appear distressed and agonized. He often was observed to be rocking back and forth and sometimes sobbing quietly in his cell. He was not eating and had very little interaction with other inmates or officers. He did not appear to be able to talk about his feelings with anyone who attempted to encourage him to eat or talk.

On his third night in jail, Bill was found hanging in his cell by a sheet that he had wrapped around a light fixture in the cell. He was dead by the time he was discovered by his cellmate, who attempted to get help in pulling him down. It was later determined that the charge against him was false. His daughter admitted that she had made the accusation as a way to get back at him for making her angry several days earlier.

* * *

These are just two examples of situations where mental illness was an important factor in incidents that resulted in significant harm. It is clear that early recognition of these problems may have prevented these unfortunate events. An understanding of the nature of certain mental illnesses and personality disorders can be helpful when attempting to develop a behavioral plan to address the problems of your prisoners, which will help ensure safety for everyone in the prison and maintain the order and discipline that is so important to the correctional setting.

For many years, inmates with serious mental health problems did not have access to treatment in many of the institutions where they were serving time.

This changed significantly when the Supreme Court mandated that those with serious mental illness be identified and treatment be provided to them. One important reason for writing this book is to help correctional officers identify persons with these severe and persistent mental illnesses so that these identified individuals may obtain treatment for that purpose. Another reason for writing this book is to allow the officer to have a general knowledge of mental health, and know how to distinguish less severe mental health problems (which may cause a great deal of suffering, nonetheless) from the more severe problems, which require immediate treatment. A general awareness of mental disorders and mental health issues will be very beneficial to correctional officers both in managing their job and their personal life.

Even though people with severe mental illness are the only ones that we are required to treat by law, other mental disorders and mental distress may be the cause of many problems that you will encounter on the job. The most obvious example of this is suicidal behavior. Although persons with severe mental illness are at increased risk for suicide, they are by no means the only inmates who might attempt suicide. Being familiar with the various forms of mental disorders and the ways that inmates may respond to extremely stressful situations will enable the correctional officer to do a better job of preventing these incidents from occurring.

Each state and locality may differ in the treatment it provides for substance use, predatory sexual behavior, and a variety of other mental disorders. Even when treatment or rehabilitation programs cannot be offered to inmates who suffer from one or more of these problems, the correctional officer who recognizes and has some understanding of these difficulties will be more effective and safer on the job.

Although many people still do not consider substance use problems a mental disorder, there is no question that they affect a majority of inmates in most correctional settings, and that may have a very significant impact on the management of the correctional environment. In addition, substance use is the mental health problem that is most likely to develop in correctional personnel. An understanding of these problems will be of great value to anyone who works in correctional settings.

When we speak of recovery in the context of treating mental disorders, we should be clear that this does not imply that persons affected by mental illness will be cured. Recovery refers to individuals' ability to manager their illness effectively and to achieve relative stability of the symptoms they experience. Recovery from mental illness is possible for many who suffer from a mental disorder no matter how severe that illness might be; a cure is not possible.

Behavior problems and psychological distress are becoming increasingly common in jails and prisons, as we shall see in the next chapters. Sometimes, they are caused by preexisting mental illness, but they may result solely from the experience of being incarcerated. Particularly when correctional facilities are crowded and used for populations they were not designed for, this experience is very stressful, even for the toughest person. In this potentially explosive situation, the seemingly unpredictable behavior of the disturbed or mentally ill inmate makes the job of controlling the population more complicated. We know that prisons and jails commonly have become homes for persons with significant mental health problems. Correctional officers are being asked to take on both the role of confessor and enforcer. At times, this is confusing and sometimes frightening to the mentally ill inmate. When inmates view their environment as hostile and unresponsive to their needs, they may act on their fears and struggle to gain some control. For the correctional officer, these dual roles may feel confusing and contradictory, as well.

There are several basic steps which can be helpful for dealing with mental health issues in jails or prisons. These can be defined as (1) engagement, (2) recognition, (3) assessment of immediate danger, and (4) referral to appropriate treatment sources. The first step, engaging an inmate about whom you are concerned, is perhaps most important. This can be described best as simply developing a dialog and listening as this person talks to you. If he or she is not open to direct communication, it simply may involve observing his or her behavior and noting anything which seems out of place. Often, people will open up and begin discussing their thoughts if they feel they are not being judged. Through the dialog process, we can begin to move toward the second step, which is recognition.

Recognition begins only after developing a basic understanding of mental health problems. Through interactions with an inmate, one can look for behaviors that will impair his or her ability to cope in prison. Observations and input from other officers also can be very helpful at this stage. If you see a pattern of behavior that may cause disruption or danger, carry out the third step, an assessment of immediate danger. Specific questions may be used to gather information about the likelihood of suicide or aggression, and make a judgment on the need to proceed to step four, making a mental health referral. Professionals with the mental health service will assess the need for a more protective setting. Hopefully, consultation with the mental health professionals will enable you to improve your understanding of the problem and to confirm your ability to accurately assess inappropriate or dangerous behavior.

This book should help you understand behaviors and other phenomena related to mental illness and allow you to employ these four steps easily. We believe that this knowledge can make your work as a correctional officer a bit

easier. It is also important to the inmate with mental illness. These persons are often victims as much as perpetrators. Only adequate knowledge about these problems can ensure that inmates with mental illness are protected from the confusion in their environment and that the symptoms of their illness are minimized. The information contained in this book should shed light on things that you already have seen or will be likely to see in the near future. We hope that you find it useful on a day-to-day basis. We hope that it will help you to avoid confusion and do a better job of protecting yourself, your coworkers, and your charges. This can reduce the amount of stress you experience and help you manage your responsibilities more easily.

—Wesley Sowers, M.D.

Mental Illness in the Correctional Setting 1

Mental health problems are becoming increasingly prevalent in jails and prisons. The correctional officer faces inmates who have a variety of problems, which generally were reserved for state mental institutions in the past. In addition, a large number of mental health problems that inmates experience are not so obvious, but can have serious consequences for the inmate and the people around him or her in the correctional setting. Traditionally, correctional officers have not received a great deal of training about how to recognize and react to the problems they likely will encounter. Such training can make your difficult job a little bit easier. This book is a starting point in that training process.

There are probably a variety of reasons that mental health problems and severe mental illnesses are more common today in correctional settings than in the past. Sometimes, mental illness can cause someone to break a law. In recent years, we have seen hospital services for persons with severe mental illness cut back, without providing them with adequate care in the community. This has left some people who suffer from these illnesses unable to care for themselves when they are the sickest and often leads them to get involved in activities that are illegal in order to survive, or in some cases, because they are unable to control their behavior without adequate treatment. We see this most commonly when dealing with people who are homeless. The percentage of homeless persons who are being detained in our jails has increased dramatically over the last few years.

There have been many other reasons suggested for the large amount of mental illness and the high use of mental health services within correctional facilities. We briefly mentioned the reduction in resources available in the state hospital system. This is referred to as *deinstitutionalization*. It may be more

accurate to say that the institutional setting only has changed, and that many of the patients formerly taken care of in hospitals are now housed in prisons.

There also has been an increase in arrests related to drug offenses, and punishments for these offenses have become more harsh and less flexible. Persons with mental illness are more likely to use substances and to develop problems related to them. Persons who are addicted to drugs or alcohol are much more likely to develop a mental illness than those who do not use. It is not surprising then, that we would see more mental illness in our jails and prisons. Depression, suicidal thinking, aggressiveness, and irritability are very common problems with persons who use addictive substances, and these people are also much more likely to have problems controlling destructive behaviors related to their feelings.

Nationwide, there has been an increase in the number of persons who are incarcerated, and there are inevitable problems with crowding. We know that crowded conditions cause a great deal of stress, and as we will discuss in greater detail later in the book, stress is related to mental illness in significant ways. Even for persons who enter the correctional system without significant mental health problems, stress may cause them to develop such problems following their incarceration. For those who do have such problems when they come in, often these problems become much worse under stressful conditions.

What does this mean for the correctional officer? Prison personnel inevitably will be faced with difficult problems related to mental health, and this fact is often the source of a great deal of stress on the job. This stress can be reduced, somewhat, simply by having some knowledge of what you are facing. By developing an awareness of how the risk of developing mental illness can be reduced, and by developing plans for reducing stress in the prison environment, your job can be much more enjoyable.

From your own experience with persons who have been arrested, you probably are not too surprised to learn that there is a large amount of mental illness in both the jails and prisons. As you know, this is a population that may be involved in a number of risky behaviors. These behaviors lead to a high rate of HIV infection and frequent episodes of physical trauma in addition to mental illness.

They often either have been the initiators of, or the victims of violence, and it is not unusual for them to have experienced sexual or physical abuse at some time during their development. We know that violent people often come from violent environments. When an early upbringing has been extremely unstable, people generally have difficulty with emotional control and relating well to others. Their relationships often have been full of conflict, and they

have a great deal of trouble dealing with loss. While these conditions often are associated with more subtle forms of mental illness, they can cause significant problems in a correctional setting. One of the questions we want to help sort out is: how do we differentiate the psychological distress people experience from mental illness?

Before considering the specific forms of mental illness, it might be useful to take a look at some statistics on these problems. As we mentioned before, homelessness is increasingly common among prison inmates and also among persons with mental illness. A study done in Philadelphia, Pennsylvania, in 1992 looked at inmates who were seen at the jail mental health program over a six-month period. They found that 31 percent of the sample were homeless at the time of entry into the jail system. Those persons with the most severe psychiatric disabilities were most at risk for homelessness. It is even more interesting when you begin to look at the reasons why these persons became incarcerated. Many studies have been done that have looked at this since deinstitutionalization has taken place. What do they show?

A prevalence rate refers to the percentage of people in a given population that are affected by an illness. When prevalence rates were examined in a random sample of 728 male jail detainees, 67 percent had some disorder more serious than emotional or personality problems during their lifetime. Severe personality problems affected more than 50 percent of the inmates, however. More than 30 percent had either a severe mental disorder or a substance abuse disorder. Detainees with severe mental disorders were most often in jail due to nonviolent crimes. While the exact figures are unknown, the rate of mental disorders in the general population is about 10 percent at any point, and almost double that when substance use problems are included. Although this may seem surprisingly high to some, it is clearly much lower than the rates in prison populations.

Although mental health problems often have been neglected in prison settings in the past, there has been a greater recognition of mental illness recently. Over the past ten years, there has been a marked increase in the provision of mental health services within adult correctional facilities due to concern about reducing suicide and controlling the level of violence. In fact, an increasing number of facilities are providing services ranging from twenty-four-hour hospital mental health care, residential treatment programs, counseling, therapy, medication monitoring, testing and assessment. The Inventory of Mental Health Services (1988) showed that at least 10 percent of state prison inmates receive some form of counseling or supportive therapy from mental health professionals over a period of one month. About 5 percent were being treated with medication or being evaluated for psychiatric treatment. We will be considering various forms of treatment in more detail later in the book.

At certain times during the course of incarceration, the likelihood of developing mental health problems seems to increase, usually at times of intense stress. One of these times is during the first week of incarceration. If problems can be identified and given needed attention at this point, more severe problems and potentially dangerous behaviors may be avoided. Often, persons with severe mental symptoms can be incarcerated despite being charged with minimal offenses. A study of inmates in California county jails found that 6.7 percent had a severe psychiatric condition at the time of their admission interview. Timely treatment can decrease this type of symptomatology during the period of incarceration and also after release. Table 1 shows rates of various mental illnesses in prison and general populations.

Table 1.1: Percentage of Severe Mental Disorder in the General Population and Among Jail Detainees

	Major Depression	Schizophrenia	Mania	Any Severe Disorder
General Population	1.1	0.9	0.1	1.8
Male Jail Detainees	3.4	3.0	1.2	6.1
Female Jail Detainees	13.7	1.8	2.2	15.0

From L.A. Teplin, 1990 and 1994. *American Journal of Public Health*, 80:663-669 and 84(2): 290-293.

Suicide is one of the most severe consequences of mental health problems both in and outside of correctional settings. Suicidal thinking and behavior are quite common in jails and prisons. A great deal of energy and resources have been directed toward decreasing the number of suicides within correctional facilities over the past few years.

Despite these efforts, suicide rates remain unacceptably high. Experience suggests that efforts of this kind can be thwarted if all correctional personnel have not been adequately trained to understand events that may lead to suicidal behaviors, and when to take threats seriously. All prison and jail officials—both juvenile and adult—should be aware of the risk of suicide and what can be done to prevent it.

What do we know about the population who appears to be at risk for suicide? First, what may lead people to contemplate suicide? In the general population, those who make life-threatening attempts are more likely to have had prior attempts and to have suffered a recent major loss such as becoming unemployed or undergoing a marital breakup. Suicide appears to be strongly related to feelings of hopelessness. Hopelessness also seems to decrease one's ability to handle the stress of incarceration. Those who come into jail feeling that they have little reason to live may have irrational and negative beliefs about their chances of surviving incarceration.

Persons who are extremely lonely or who have no one who cares about them outside of the correctional facility may begin to see their existence as meaningless. Inmates such as these are at high risk for developing suicidal ideation and behaviors.

Sometimes, acute stressors can set off suicidal thoughts. Getting into fights, feeling frustrated, or receiving bad news from home, all may be sources of stress. One simple way to reduce some of these stressors is to let the inmate tell his or her story. It usually is not even necessary to offer advice, but some indication of caring and understanding sometimes can be very helpful. When someone is feeling angry and bitter about something such as a perceived humiliation, they are less likely to "snap out" if they have been able to vent their anger and frustration. It is also okay to ask people if they are feeling despondent or do not want to live any more. Contrary to popular mythology, this does not make them more likely to commit suicide. It is usually a relief to them to be able to discuss these feelings.

Data on suicides over the past few years has given us a greater understanding of the phenomenon. More than 50 percent of suicides occur within the first three days in jail, and most often, occur when an inmate is placed in isolation. These incidents also occur more frequently as an inmate approaches a court date. Hanging is the most frequent cause of death (Steadman, McCarthy and Morrissey, 1989). Most of these persons who committed suicide had a major psychiatric disorder, and a large percentage had a history of previous psychiatric treatment. A survey of state and federal correctional facilities found that about 6 percent of inmates had a *severe* mental disorder at the time of their incarceration (McCarthy, 1985). This shows the need to identify those at risk and link them with mental health services. Correctional officers should be especially cautious during these periods of high risk. Avoid housing risky inmates alone, for example.

Similar to suicidal behavior, violent and aggressive behavior is also multidimensional. Control of violence is of paramount importance in correctional settings. An understanding of how certain mental illnesses can affect the behavior of an inmate can help correctional personnel respond in an effective manner.

Some behaviors can be controlled with treatment and medication. Others require specific attention to the conditions surrounding the inmate. Some prisoners, for example, may not be able to tolerate close physical contact with others, or verbal taunting without acting out in a violent way. When this is the case, it may be necessary to remove that inmate from the inflammatory situation temporarily until a complete plan can be devised.

How do the symptoms of mental illness contribute to the possibility of aggressive behavior boiling over into violence? Numerous factors contribute to an environment which fosters violence, but more often than not, inmates may feel endangered and unprotected, especially when they initially are detained. Excessive suspiciousness and feelings of persecution may be part of some mental illnesses, and this will intensify these fears and feelings of vulnerability. In addition, problems with mood, such as irritability, negativism, or unhappiness can lead to active aggression if a difficult situation presents itself.

Inmates with certain mental illnesses may be more prone to violent behaviors, but often persons who are incarcerated are at high risk of developing violent behaviors for reasons other than their mental illness. Frequently, they have been exposed to violent behavior as a child. A large number of these violent inmates may have a history of prior head trauma. Neurological damage increases the risk of impulsive behavior.

It commonly is believed that substance use contributes to violent behavior. This is especially true when drugs (including alcohol and stimulants) are used because they reduce a person's ability to control angry feelings. With other substances, most violence appears to be related to the trading of an illegal substance rather than a direct consequence of intoxication. Drug trading often does lead to violence in the jail or prison setting. As with suicide, stressful circumstances often lead to the commission of violent acts. While many prisoners have learned to talk tough and frequently make threats of violence against other inmates, in many cases, inmates will express concern that they may lose control and request protection from their own impulses. These requests for help should be taken very seriously, and a mental health evaluation should be arranged.

This chapter has attempted to provide an overview of some of the common mental health problems often encountered in the correctional setting and some estimates of the prevalence of these difficulties. Correctional officers who are familiar with the common presentations of mental illness and emotional instability will be more effective in identifying problems before they occur and will make the work environment safer and more fulfilling for themselves and their colleagues, as well as for the inmates under their observation.

In the following chapters, we will take a closer look at some specific types of mental illness and how they may be present in the correctional setting. Later chapters will focus on the causes of mental illness and how they can be treated. The correctional officer's role in identifying and working with inmates who have mental problems will be discussed in more detail.

Substance Use Disorders

2

Steve began drinking when he was fourteen years old. Many of his friends had started drinking even earlier and had no trouble getting what they needed. Steve's father was a heavy drinker, and he was unhappy at home and seemed to always be fighting with his father and his older brothers, who also had started to drink and use drugs. Even though he did not like the taste of alcohol at first, he found that it made him feel better when he drank, and he forgot all his worries. In a short time, he found that he would really look forward to getting drunk. He did this on weekends when he was a teenager, but it became more frequent after he finished school and moved out of his parents' house. He moved in with some friends and began to experiment with other drugs and began to deal on a small scale.

Most people would have described Steve as a sweet but quiet person. He generally minded his own business and was kind and considerate to others. Some people said that he thought more about others than he did about himself. This demeanor changed sharply when he was drunk, though. He usually became very talkative and often loud. In some cases, his loud joking could turn to anger, and it was not unusual for him to get into fights with strangers who told him to chill out. He began to have trouble remembering these incidents and other events the morning after heavy drinking. He found the stories that people told him about his behavior hard to believe. It was hard for him to imagine himself behaving in that way.

As time went on, he began to use other substances with the alcohol, especially marijuana and cocaine. He would take a cut of

what he sold for himself and his friends. He was arrested the first time for assault and public intoxication. He was carrying some marijuana at the time of his arrest, and also was charged with possession. He got off with a light sentence for this first offense, and it was not long before he was out again and eager to have a drink. He really did not see that his difficulties were related to his drug and alcohol use, or at least, he would not admit it. He was only happy when he was using.

Things did not go well for him after he got back to the street. His drug contacts had gone elsewhere. Many of them had been looking for more dependable dealers even before his arrest. He was having a hard time paying bills, and one night while drinking with a friend, he agreed to help with the robbery of a local convenience store. It would give him enough money at least to continue his high that night. Things did not go well, though, at the store. Unfortunately, they brought a gun. The shop attendant had been robbed in the past, and would not cooperate, despite their threats. Steve became enraged, jumped over the counter, and began beating the attendant with the gun. In the struggle, the gun went off and the attendant fell, blood coming out of his chest. Steve was stunned, and began to realize what he had done. His friend was able to make him move, leaving his seriously injured victim. They were able to gather a few dollars from the cash register before they began to hear sirens. They did not get far before they were arrested. Steve did not consider the possibility of getting caught, and this time, when he was searched, he was carrying a small amount of cocaine. He turned twenty-two years old the next day.

* * *

Substance use disorders are among the most common of psychiatric disturbances. This is especially true in jails and prisons. A large number of persons serving time in jail or prison are there due to their involvement with habit-forming substances. Substance dependence often brings people into conflict with the law. While the public often assumes that users are unable to continue their habits once they are incarcerated, those familiar with the corrections systems are aware that substance use may continue to occur behind bars. Inmates and other persons with substance use problems are willing to exploit the system and find ingenious ways to smuggle substances into correctional settings. The use of substances may have a significant impact on the behavior of an affected inmate and may create situations that are extremely difficult, and sometimes dangerous, for corrections personnel to manage.

There are many misconceptions about substance use, particularly concerning what defines "normal" as opposed to "abnormal" or "uncontrolled" use. As with other mental illnesses, the line is sometimes very difficult to draw. This allows many people to convince themselves that they have no problem with their use, when, in fact, they may have very little or no control over their consumption of a substance or over their behavior once they begin to use.

Clearly, not all persons with substance use problems fit the stereotype of a whacked out "junkie" who lives only for the next hit. Many persons who have serious problems do not consistently display use-related behavior that is obvious to everyone, and this is true of inmates as well as persons outside the correctional setting. Closer examination frequently reveals significant problems and disruptions of normal functioning, however.

What is considered "normal" use? Most people use some form of an intoxicating substance at some time in their lives, and many people use alcohol or some other substance on a regular basis, often in social situations. This is sometimes called "recreational" use. People often use moderately for many years without significant change in their behavior during or following episodes of use. As long as these patterns do not change, this type of use generally would not be considered problem use.

What does describe problem use, then? For many people, substance use does lead to behaviors or circumstances that have a negative impact on their lives. Each individual may have a slightly different pattern, but commonly, people find that they may behave uncharacteristically when they have been using, or may become involved in some risky or otherwise dangerous behaviors.

The way they function following episodes of use may begin to change, as well. In some cases, use causes people to feel physically ill the following day, as in a hangover, or it may cause them to feel extremely irritable or depressed. These changes in normal patterns of behavior and feeling, in turn, may cause other difficulties. Problems may develop with family members or friends, work or school performance, and attendance may suffer, and other responsibilities may be neglected. In some cases, particularly after prolonged use, health may begin to deteriorate. In general, when use continues despite the development of many of these negative consequences, it should be considered to be a problem.

Two types of problem drug or alcohol use often are distinguished. The first type is defined simply as continuing use despite the occurrence of recurrent social, occupational, psychological, or physical problems related to that use. This is usually called *substance abuse*.

The second type is even more severe in that in addition to continued use in the face of several related problems, people begin to experience even more

difficulties. They may develop significant tolerance for the substance they use, causing them to need much more to achieve the effect they desire. They may begin to develop withdrawal symptoms when they are unable to obtain their substance. In addition to these physical changes, they may find that they frequently are using more of the substance than they intend to, or that they use it more often than they would like. At the same time, they find that efforts they make to cut down or control their use are unsuccessful. Often, they lose interest in activities that once were important or enjoyable for them. They may find that most all of their time is spent either obtaining the substance, using it, or recovering from it and that they are powerless to control this pattern. When the problem progresses to this degree, it is called *substance dependence*.

Much debate has occurred over whether substance use is an illness or simply a failure of willpower and moral strength. It seems fairly clear that in the early phases of the addictive process, choice does play an important role in substance using behaviors, and few physiological changes have occurred.

It is equally clear, however, that in the final phases of addiction, the user has no real choice over whether to use; control is lost and physiological changes often help to determine behavior. The transition from the early phases to the late phases is a critical period when it is very difficult for users to recognize the changes that are taking control of their lives and leaving them helpless.

During this period between the two extremes, substance-using behavior may become more and more ingrained as a way to avoid problems and especially unpleasant feelings. Even before many of the biological changes take place, people can develop extreme emotional dependence on the substance that they use, and they may begin to feel that using is the only way that they can cope with problems in their lives. It often is said that no one chooses to be an addict. That is to say that while people may choose to use a substance at various times in their lives, it is never with the intention of becoming an addict. By the time someone realizes that they are dependent, it is often too late to simply make a choice not to use.

Is addiction different depending on what substance people use? The process of addiction is very similar for all substances, but particular aspects of the disease vary according to the substance used. For example, crack cocaine produces a very intense but brief euphoria, and dependence may develop over a very short period of time (sometimes weeks or months), despite that fact that there are no physical symptoms associated with withdrawal. Alcohol, on the other hand, produces a high that takes somewhat longer to develop and which lasts over a longer period of time. Dependence on alcohol may develop over many years and often is associated with a severe physical withdrawal syndrome.

Despite these differences, the mechanisms in the brain that control addictive behaviors are affected similarly by both these substances, and, in fact, by all substances that are commonly misused. There is a portion of our brain that processes what we experience as pleasure, just as there are circuits that are responsible for our experience of pain. Various experiments show that this pathway for pleasure is stimulated by all of the substances that commonly are used habitually. That means that every time an addictive substance is used, that act is reinforced by the experience of pleasure. This, of course, simply provides a biological explanation for what we all have observed in our daily lives: the more persons use, the more they are likely to use again.

There has been some disagreement in the past about whether we can be successful in changing people who are addicted to a substance once their dependence has been established. We all know of people who have tried to stop, but could not resist using for very long. Many of these persons have undergone several detoxifications and treatment programs which did not appear to be cures. These types of observations have led many to believe that treatment does not work, and that people cannot change unless they really want to change.

What we seldom recognize is that many other common illnesses are not curable, and that they may have a fluctuating course over many years. For most of those illnesses, such as diabetes or high blood pressure, people may need to be in treatment for many years. By changing some of their behaviors and following a treatment program, they usually are able to improve their chances to avoid many of the most disabling aspects of these diseases. The same can be said for alcohol dependence and other chemical dependencies. While everyone does not achieve complete abstinence the first time that they try, over the course of time, treatment does reduce the frequency and amount of use for an individual, and it also reduces the number of adverse consequences associated with substance use.

One of the adverse consequences associated with substance use is, of course, legal difficulties. It repeatedly has been shown that persons who become involved in treatment are less likely to commit crimes than those who do not, whether they have entered treatment voluntarily or not. For this reason, it makes sense to provide treatment to persons who are in prison for drug-related offenses.

Traditionally, treatment for drug and alcohol dependence has focused on the twelve-step Alcoholics Anonymous (AA) fellowship approach to maintaining sobriety. Incorporating this philosophy, treatment programs have developed a variety of other group and individual therapies and educational experiences, which help addicts develop coping skills, interpersonal skills, and knowledge about addiction and relapse prevention.

Today, treatments are becoming more sophisticated and individualized to meet each addict's needs. Many of the elements mentioned still remain, but new techniques and even medications gradually are being developed. Increasing the availability of treatment, and providing incentives for treatment among jail and prison populations, could go a long way toward decreasing the prevalence of these very destructive illnesses and reduce many of the other mental health problems commonly encountered in these settings.

Problems with Mood 3

John was arrested for drug possession with intent to sell. Charges of credit card fraud also were brought against him, and he was convicted on all counts and sentenced to the state prison. He had been involved in illegal activities on and off over most of his adult life, but he had been lucky in that he had never been arrested for any major offense in the past and never had to serve any hard time. He had a girlfriend and a family who cared about him, although they were quite surprised to learn of his behavior.

He appeared confident when he entered prison. Although he was not happy to be there, he had always had an easy time figuring out how to get by, and even flourish, in all kinds of situations in the past. People always liked John, regardless of their character; people were drawn to his friendly, easygoing style. He always had gotten along with both good and bad people, and had relied upon good looks and charm to make his way.

During the early part of his sentence, things went much as he had expected, and he quickly fell in with a group of operators in the prison and became involved in gambling with cigarettes and procurement with several others in the group. He became a favorite of one of the bosses, and when he fell behind with his gambling, this man did not hesitate to cover his debts. This help did not come without a price, however. One night he was called to his "friend's" cell to pay his debt in another type of currency. At first he tried to refuse this man's advances, but was warned in no uncertain terms what might happen if he continued to refuse. Frightened, he gave in to the demands placed upon him.

Shortly after this incident, he requested lock up, fearful that he might be subjected to similar demands in the future. While in lock up, he became more and more ashamed and confused. He felt disgusted with himself and found it difficult to talk about his distress and what had happened to him. He worried that his girlfriend would know what happened to him and would be disgusted, as well. He began to think about this incident and circumstances related to it much of the day, and he had problems sleeping at night. When he finally did get to sleep, he often woke up after only a few hours of sleep. As weeks turned into months, things did not improve. He rarely spoke to anyone and did not want to leave his cell when he had opportunities to do so. He felt tired all the time, and there was really nothing that made him feel better. He stopped communicating with his girlfriend and family, and often found himself in tears. He no longer thought of what he would do after his release, and he began to feel that only death could end his pain.

During a cell search, a correctional officer found a shank (a homemade knife) in his cell, and when questioned by a sympathetic correctional officer, he admitted that he had been thinking of cutting himself. He then was transferred to the hospital unit where he could be observed more closely and obtain treatment.

* * *

This chapter concerns mood problems that people may develop. First, let us discuss exactly what mood is because "mood" may mean different things to different people.

Usually, we hear the word "mood" used as a way to describe how people feel or behave. Someone might say, "I'm in a bad mood today," or "I'm in a happy mood today." Usually, when people talk about mood, they are talking not just about how they feel at the moment, but how they feel over a period of time.

So, a *mood* is a general state of mind or emotion, which lasts over an extended period of time, usually at least a few hours, and often over a period of a day or more. Sometimes, people have problems saying how they feel and may not be aware of any particular mood they might have, or they may have trouble explaining the way they are feeling, but usually, people are able to describe their mood in some way.

In fact, people have a variety of ways that they might express how they are feeling. Often, we do this without using words. We often can tell just by the expression on peoples' faces what kind of mood they are in, or we may be able to tell something about persons' moods by seeing the way that they react to a

certain situation. For most people, it takes some practice to be able to understand what their mood is and to express it in words.

What are some of the words that are used to describe different kinds of moods? One of the first determinations we make is whether we are happy or sad. People express sadness in a variety of ways. They may say that they are depressed, bummed out, blue, down, or empty. When people feel good, they might say they are feeling high, silly, calm, energetic, cool, elated, content, or happy. People describe other kinds of moods, also. They may say that they are feeling touchy, nasty, angry, "pissed off," edgy, or irritable. At other times, they may say that they feel scared, frightened, anxious, nervous, spooked, jittery, paranoid, or just upset.

For most of us, mood changes from time to time. Some people report or display changes of moods more often than other people, but we all have these changes, and when our brains are working right, our mood reacts to changes in the world around us. What kinds of things usually have an effect on our mood? Again, while this may vary somewhat from person to person, several things commonly affect our mood.

Perhaps one of the most common things affecting moods is weather. When the sun is shining or we are out in weather that we find pleasant, it usually makes us feel good. For some people, just the lack of access to the outdoors may be a source of discomfort. Many people in jail experience feeling cooped up and edgy, for example.

The quality of our sleep is another thing that may affect our mood. When people sleep poorly, they often reported feeling irritable or depressed the next day.

Food also may have an effect on our mood. Sometimes, when we are able to eat something that we really enjoy, we feel good, or on the other hand, if we do not get any food that we enjoy, we feel frustrated or bummed out.

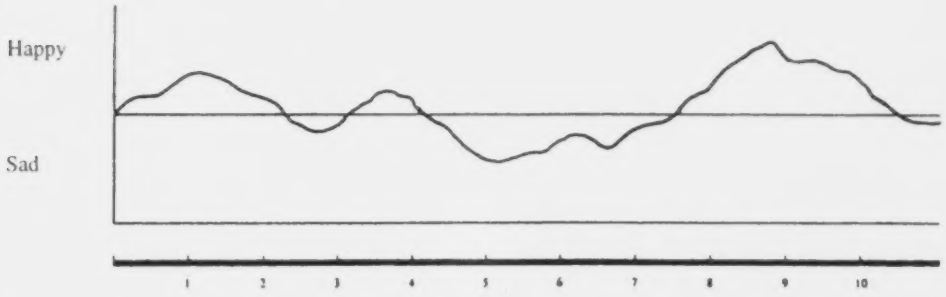
Relationships that we have with other people also can be very important in determining our mood. When other people treat us well or give us the respect and recognition that we deserve, it usually makes us feel good. On the other hand, when people treat us badly, when they take advantage of us, treat us as if we are unimportant, or otherwise disrespect us, it can make us feel quite bad. This is especially true when these interactions involve people whom we care about the most, such as family members or persons we may be involved with romantically.

Our moods may shift quite a bit depending on whether we are feeling successful or unsuccessful, however we think of success. Whether or not you think about success in the same way that others around you do, almost all people experience pleasure when they accomplish something they had been hoping to achieve. We all feel disappointed when we fail to achieve our goals. Sometimes

people think about this as lucky or unlucky. Of course, it is difficult to feel happy when your luck is not good.

So, for most people in good mental health, mood changes are common and often occur in relation to what is happening around them or sometimes inside them. If we wanted to draw what a normal mood pattern looked like, we probably would draw something like the pattern in Figure 3.1:

Figure 3.1: Normal Mood Pattern

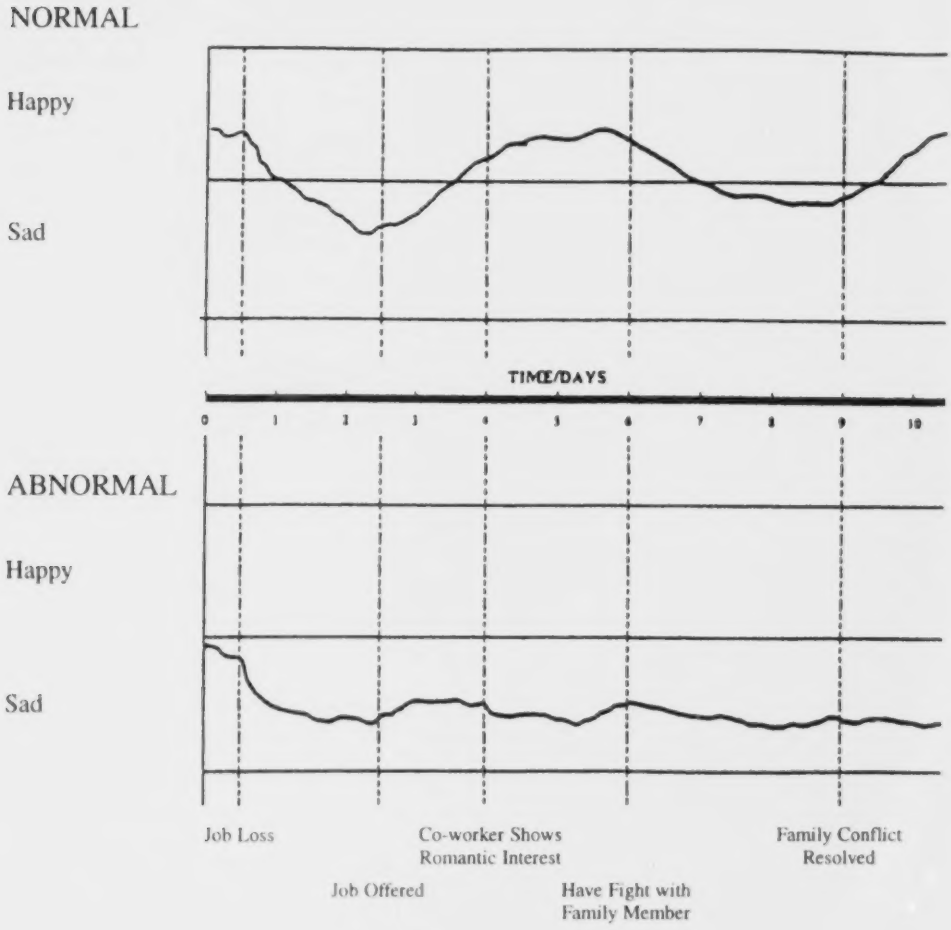


When this pattern of mood variation is disrupted, and when those changes in mood regulation cause persons to lose their ability to function as they normally would, they have developed a mood disorder. The mood disorders that people commonly experience may take several forms. Regardless of what form they take, when people develop this type of illness, their moods do not respond to the things that are happening around them as they normally would. The conditions that were discussed no longer have the same effect on their mood as they did in the past. Their mood is controlled much more by internal biological and psychological events than by external events.

Some people have suggested mapping mood changes as one way to determine whether your mood is reacting normally to changes in your environment. If the map or chart does not show a normal reactivity of moods, it may mean that you have developed a disorder of mood. The two charts in Figure 3.2 (on the next page) show examples of normal and abnormal mood reactivity.

One of the most common mood problems that people develop is when their mood becomes "stuck" in a very sad state. This usually is referred to as *depression*. When people suffer from depression, they may experience several difficulties besides sadness. They may find that they have trouble thinking clearly and concentrating on things with which they would normally have no difficulty, and many people report that they feel very nervous. They often lose

Figure 3.2: Mood Reactivity



interest in activities that they would normally enjoy, and they have difficulty finding pleasure in most activities or entertainment.

At the same time, they may notice changes in the way their body normally works. For example, they may have difficulties with sleep, or their appetite may change resulting in a weight loss or gain, or a person may feel exhausted or drained of energy. There is usually a loss of interest in sexual activity, and frequently depressed people feel like crying or actually do cry unexpectedly. Sometimes, they are not aware of what causes the tears.

Once some of these changes have been established, changes in thinking may develop. People often begin to feel that there is little hope that things can change, and that there is little anyone can do to improve their situation. They

often develop a very low opinion of themselves. They may feel that they are to blame for their situation and all the things that have gone wrong in their lives and in the lives of those about whom they care. When this situation continues for a while, it is not unusual for a person affected by this illness to lose the will to live, and there is a danger that they may actually make an attempt to end their life.

Another serious complication of depression when it becomes severe is a disruption in the way a person thinks. This will be discussed further in the next chapter on disorders of thought. For the moment, it is enough to say that persons may become confused and believe that things are happening around them which really are not happening at all. When a person develops this type of illness, it often is difficult to predict how long it will last. Without treatment, a severe depression of this kind may last weeks, months, or in some cases, for years. Once persons have experienced one episode of depression, it is more likely that they will develop another episode at some time in their life. Treatment is usually effective in limiting the length and severity of this illness, and this will be discussed at greater length in the chapter on treatment.

Another type of mood disorder that is common is almost the opposite of depression. As mentioned in the previous discussion, in depression, everything slows down and persons' energy becomes drained; they become uninterested in the things that are happening around them. Mood can be altered in the other direction, as well. When this is the case, persons may seem to be speeded up. They have an excess of energy and enthusiasm. They have difficulty sitting still, and may talk rapidly and almost endlessly! They have a difficult time keeping their mouths shut. They often report feeling extremely happy or confident, but sometimes, their mood may be extremely irritable and angry rather than happy, and they easily may be provoked. In most cases, these people may have an exaggerated idea of their abilities, power, and influence. They feel that they are capable of doing things they have never done before and which are often completely unrealistic. They experience changes in the way that their body normally works, also.

They may sleep very little or not at all, but they do not feel tired. They may not remember to eat and often say that they do not experience hunger despite their increased activities. Sexual interests often increase, and they may become tireless in their pursuit of sexual activity without much concern about whom they become involved with or in what way.

It is easy to imagine that these alterations in persons' moods and the way that they think about themselves could lead them to make some very bad decisions that would lead them into trouble. This is often the case. People may spend money as if they had an endless amount of it, or they may feel that they are entitled to take things that do not belong to them. They may become

involved in sexual activities that place them in danger of illness or which destroy or hurt a relationship with someone about whom they care. They may become involved in a variety of other activities which place them in danger which they do not pay attention to or simply misjudge. They might drive a car wildly, for example, or take other kinds of risks that are unreasonable.

When people develop this type of illness, it may last for several weeks or longer if they receive no treatment. Having this type of problem once makes it more likely that similar episodes will occur in the future. It also is likely that persons who have experienced this type of mood change, which is sometimes called *mania*, also will experience periods of depression at some time in their life.

The severity and course of this illness varies from person to person. Fortunately, most people who suffer from this type of illness respond to treatment which can reduce the severity, the length, and the frequency of episodes. As with depression, when this illness becomes severe and is not treated, disturbances in thought may develop that make it impossible for the affected person to stay in touch with reality. When this occurs, it can put affected persons in great danger either from exhaustion or from purposely or unintentionally behaving in a way that puts their life at risk.

Moods are an important part of our experience regardless of whether we are free or confined. While we have seen that mood normally varies depending on our circumstances, and that it is natural for people to feel depressed from time to time, it is likely that people who are confined in jails and prisons will be more likely to be unhappy a greater part of the time than persons who are not confined. This does not necessarily mean that an illness is present, but again, people in confinement are more likely to develop mood disorders than persons who are not in jail or prison. When moods are unchanging and unreactive to events, it is likely that the affected person is experiencing an illness of mood regulation and that help may be needed to regain healthy mood regulation.

Problems with Thinking

4

James was just twenty-three years old, but he had spent most of the past three years in institutions or on the street. He began drinking and using drugs when he was a teenager. They made it easier for him to be with people and to feel that he was part of the group. Before he finished high school, he began to feel very nervous and overwhelmed, often feeling confused about what he was doing or what he wanted to say.

Things got even worse shortly thereafter. He began to think persons were speaking to him, even though there was no one there. He began to suspect that there was something going on, and that he was being trapped. He was not sure why, but he began to think that his family was in on the plot. The voices he heard became more intense and seemed to make comments on his thoughts and often made nasty remarks about things he did. He also began to think that the local newscaster was directing messages to him from the television. This continued, and although he tried to forget these problems with alcohol and other drugs, they were helpful for only a brief period, and then, these problems seemed to be even worse. He finally was taken to the hospital by police after he became threatening to his parents and waved a knife at his mother.

He eventually was taken to the state hospital, and after several months, he began to improve on medication. He was released after almost six months in the hospital, and he returned home for a short time. It was not long before he stopped taking medication. He thought that it made him tired and depressed, and he felt like a zombie. Not long after this, his symptoms began to return, but this time,

he did not wait for problems to develop with his family, and he left home. Over the next few years, he wandered around, doing odd jobs occasionally, or collecting cans to redeem to buy some food or alcohol, and staying wherever he could, sometimes in shelters, sometimes in the street.

He also began to steal when he did not have enough money otherwise. This was the beginning of his acquaintance with the criminal justice system and jail. His symptoms continued both in and out of jail, but usually, they improved somewhat when he was taking medication. Unfortunately, he usually was not able to continue taking it after he was out on his own for a while. When he was not in jail, he was usually out on the street or in a shelter, or in some cases, he would be committed involuntarily to a psychiatric hospital.

In jail, James seemed strange. He would not look others in the eye when they spoke to him or if he spoke to them, and he avoided interactions with others as much as he could. He did little to care for himself, and often had a bad body odor. He sometimes seemed to carry on conversations with himself or to laugh for apparently no reason. Sometimes, he would appear upset, talking angrily to himself. He generally was left alone by the other inmates who seemed to be confused and almost frightened by his behavior. If he could be persuaded to take medication, some of this bizarre behavior was less noticeable, but he remained isolated.

During one visit to jail, he refused to take any medication, and then began to refuse his food. Some of the correctional officers tried to encourage him to eat, but this only seemed to strengthen his resistance. Once, he became angry and threw his tray at the correctional officer, and he was placed in a lock-down cell. When he arrived there, he refused to ingest any fluid either, and he quickly started to become dehydrated. Finally, he was sent to the hospital for rehydration through his veins, and he was given medication against his will by order of the court because of the danger in which he placed himself. He gradually improved with this treatment and was eventually able to be sent back to the general population.

* * *

One of the most common problems that people experience when they develop a mental illness is a disruption in the way that they normally think. While these problems usually are associated with more severe forms of mental illness, some less-obvious forms of thought disruption can be seen in less-serious forms of mental illness, also. Before we describe some of the abnormal

ways that people may begin to think when they become ill, we briefly will describe the way our minds work when we are healthy. While some of these observations may seem obvious, they are a good way for us to move to a consideration of thought disruption.

Think of several different jobs that we rely on our brains to perform. First, we expect our brain to help us understand the information that we gather from the world around us through our eyes, our ears, our nose, our skin, and in some cases, our mouths.

We need to be able to know that when we see something in front of us, that the person next to us is seeing just about the same thing, and when we reach out to pick up an object that we see, that it actually will be there. Likewise, when we hear someone say something to us, we need to know that what we hear is the same thing that the person next to us hears, and the same words that the speaker intended us to hear.

Secondly, we expect our brain to be able to organize all the information we have floating around in our head so that we can get some use from it. We expect to be able to move from one thought to the next in a way that allows us to think through a problem. When we wish to express our thoughts to another person, we expect that we will be able to do that in a way that someone else can understand. We need to be able to pay attention to new information that comes to us through our senses and organize it all in a way that helps us understand what is happening around us.

The third thing we hope that our brain will enable us to do is a little bit more complex: to create new ideas. Sometimes, when the information available to us is not complete, we need to be able to make the best guess we can about what actually is occurring. This sometimes is called "imagination"; we are able to think of a variety of possibilities related to a given situation based on limited information. We need to be able to judge which of these possibilities best fits our idea of the world outside our mind.

Often, we use our emotions as one source of information when we create new ideas. This is what happens, for example, when we tell a story or paint a picture. In a way, we are all a little bit like an artist who gathers information from his or her senses, mixes it with other information in memory and with feelings associated with various experiences, and creates something that represents that mixture of inputs. We give meaning to our world in this way, and when our minds are working properly, it is a meaning that others can understand even if they do not agree.

These are the major functions that we expect our brain to perform so that we can do what we need to do to survive and thrive wherever we may be. These things enable us to determine what is real from what is not. There is a reality

(we hope!) that we experience in the same way as most other people in the world. While we may disagree on what the meaning of that reality is, we all are starting with the same basic information. Obviously, when one or all of the jobs we expect our brain to perform is not being done right, it could cause us serious problems.

Looking back to our consideration of some of the brain's jobs, we first thought about how our brain gathers information from the world around us. When our brain adds information to what our senses deliver to it, the way that we experience the world changes. This usually is called a *hallucination*.

There are several different types of hallucinations. Probably the most common type of hallucination is where people hear things that are not there. Usually, this will be hearing a voice. The voice may be one that is recognized as a specific person, or it may be one that the person never has heard before. It may make comments on the person's thoughts or actions. It may tell the person to do something, or it may simply call his or her name. The individual might hear other sounds also.

There are also visual hallucinations, where someone sees something that is not there. Other types of hallucinations may be experienced, also. A person may experience something touching them, or think that they feel something crawling on them. They may smell strange or familiar odors that are not there, or they may taste something even though they have had nothing in their mouths. So, it is clear that when the brain adds information in this way, a person will not experience reality accurately. When hallucinations occur, those who experience them often are convinced that they are real and actually exist. Sometimes though, a person is able to understand that these experiences are produced by their brain.

The second way that our brains may become confused is in the way they organize information. Even when the brain is gathering all the information accurately and is not adding any information to it, if it cannot organize that information in a way that makes sense, we would have a difficult time going about our business. One way that this happens is when the brain is unable to keep focused on one topic at a time.

Usually when we are thinking about a subject, say baseball, all the thoughts that we have that are related to baseball come to our mind one at a time and follow each other in a logical way. When the brain is not working as it should though, some unrelated thoughts, or thoughts that only may be related in an odd way, may get mixed in and distract attention from what is being thought about so that it is very difficult to complete a thought and make any sense to anyone with whom the person is trying to talk.

For example, if you were trying to think about how to play baseball, you might begin by thinking about the pitcher throwing a ball to the catcher with the batter trying to hit the ball. Suppose then that you imagine the catcher throwing the ball back to the pitcher, and suddenly you begin to think about a cold pitcher of water sitting next to a clear glass. Next thing you know, you are thinking of a house with many glass windows and someone is throwing a rock through the window. As the rock flies through the air, suddenly, it lands in a baseball glove, and the pitcher is getting ready to throw the next pitch to Mickey Mantle. As you begin to imagine this, suddenly you are interrupted by a cartoon you remember with Mickey Mouse and Goofy. We could go on for quite awhile with this example, but you get the idea.

If your brain were unable to control the type of thoughts that came into your awareness, or to sort out related thoughts from unrelated thoughts, it would be very hard to accomplish anything. You would be awfully confused.

This is an extreme example of what can happen when a person becomes mentally ill. Thoughts can be extremely mixed up and unrelated to one another, or they may be disrupted more mildly so that a person has some difficulty concentrating or paying attention in the way that they normally would. Sometimes, the brain might just lose track of what it was doing in the middle of a thought, and nothing would come to mind in its place. Some people have difficulty bringing thoughts into their awareness, and so may appear to be thinking very little.

In another type of malfunction, thoughts may come too rapidly, and the individual cannot make sense of them. People sometimes report that their thoughts are too rapid for them to keep track of and that they become confused because they cannot understand them fast enough, and cannot complete one thought before another is taking their attention away. Whatever the exact pattern may be, it is not hard to imagine that it would be very difficult to do simple things like watching TV, reading a book, or even talking to a friend if your brain were working in this way.

The third difficulty that may result when a person's brain is not working properly is in the area of how the brain makes sense of the information available to it. We briefly discussed the brain's creative responsibility. When problems develop in this area, persons may develop mistaken ideas about what is happening in the world around them.

Rather than taking all available information and drawing the most likely conclusions from it, the brain, instead, may use only parts of that information and then apply it in a strange way that causes it to draw conclusions that are completely wrong. Despite that, when the brain is malfunctioning like this, persons may be convinced that their way is the only possible way to understand

the situation, and people who do not see that have something wrong with them. When someone has a mistaken belief of this type, which is held very strongly despite evidence to the contrary, it sometimes is called a *delusion*.

There are many different kinds of delusional beliefs, but some are more common than others. One type of delusional thinking is called *paranoia*. Paranoia occurs when people believe that people around them are against them or that they are trying to hurt them when there is no real reason to think that this could be the case. They may believe that people they do not know are talking about them or plotting against them. Sometimes, they may believe a whole organization such as the FBI or the Catholic Church is determined to see their downfall or even murder.

In prison, people may face some real dangers and can come into contact with people who really do want to harm them. This is not paranoia, of course, because most reasonable people would experience the situation in the same way, and they would be able to distinguish between situations where people were interested in doing them harm, and where they were not. When people have paranoid delusions, they are unable to make that kind of distinction.

Another common type of delusion is where someone begins to believe that they are receiving special messages from the TV, radio, or newspapers—sources that do not carry special messages for individuals. They may feel that they have lost control of their bodies to some outside force (such as beings from outer space), or that people are able to hear their thoughts or read their minds.

In some cases, people may become convinced that others are not who they seem to be or who they claim to be. For example, they may begin to believe that their mother is an imposter, that their real mother has been taken away and that the person who has come to see them is posing as their mother and wishes to harm them.

Another common type of mistaken belief occurs when a person begins to believe that he or she has special powers or abilities beyond those of normal people. An extreme example would be if someone began to believe that he was God and had the power to know what other people were thinking or what they will do. Such individuals may believe that they deserve special privileges, or can hurt someone else if they choose to without a penalty. In some cases, people may believe that they have been living for many years and have participated in historical events. They may claim, for example, that they were an advisor to a past president and were responsible for great discoveries or events.

These are the major kinds of thinking problems that people may experience when they become mentally ill. It is not surprising that people may be frightened by those who are suffering from mental illness, or that they might have difficulty understanding what is happening. People who have this type of

thinking problem experience reality differently than other people around them. This state of being out of touch with reality, of not being able to distinguish what is real and what is not, is sometimes called *psychosis*.

Psychotic illness may be associated with several different mental problems. People who have an illness called *schizophrenia* may experience many of these problems on a periodic basis over many years, and some may never recover completely.

Psychosis also can be seen in severe cases of mood disturbance, as noted in the previous chapter. Psychosis is also a fairly common complication of heavy drug and alcohol use. People may experience psychotic breakdowns when they are extremely intoxicated with drugs like crack, or when they are in withdrawal from use—as is often the case with alcohol. Sometimes injuries to the head, or certain types of health problems, such as severe liver disease, may cause periods of brain malfunction and psychosis. In many cases, these problems are temporary, but in others, they require treatment for a long period of time. Fortunately, as with the mood disorders, which were discussed in the previous chapter, it does help to have treatment for these conditions. Treatment will be discussed in more detail later in this book.

The problems of thinking can be very frightening for those who have experienced them. While we all may experience periods of confusion in our lives, it is very difficult to feel safe if these periods last for any extended period of time. While some people may be more sensitive to developing these illnesses, we all are capable of developing at least brief periods of psychosis if we are exposed to enough stress. As we already have mentioned, prison can be an extremely stressful place, and people who are locked up are at greater risk of developing these problems than people who are outside.

It is important to understand what may be happening if you begin to observe these problems in the prison or jail setting, or if they affect some of the inmates on your watch. If you can pick up these changes and arrange for an inmate to get help early, before the problem becomes severe, you will be doing yourself and other correctional officers a huge favor. At the same time, you will be doing a great service to the affected inmate, and those around him or her.

Problems with Nervousness and Fear 5

Grace was thirty-two years old and had been in prison for several years following a manslaughter conviction when she began to experience episodes of extreme discomfort. They began shortly after she learned of the death of her mother.

She was in the yard one day when she suddenly began to feel frightened and trapped among a crowd of her fellow inmates. She felt as if she were going to pass out at first, and then began to feel a tightness in her chest and had some difficulty catching her breath. She began to sweat and tremble, and she felt nauseated. She tried to get away from the crowd, but felt closed in, and she began to feel as if she were going to die. She fell to the ground, gasping for air. She was rushed to the infirmary, but the tests that they ran there showed no abnormality. After about twenty minutes, she began to feel normal again, and she was allowed to return to her block.

After this incident, she was afraid to go out in the yard or to be too far from her cell. She feared that she would have another attack. Despite her efforts to avoid crowded situations, this was not easy in prison, and she began to experience similar episodes every few days, sometimes even at night, waking her from sleep. These episodes were not always as severe as the first one, but they still were very uncomfortable. She requested transfer to a self-lockup, hoping that isolation would improve her condition. The move did not help though, and most of the correctional officers thought that her complaints were not genuine. They felt that she had a hidden agenda and that the best way to deal with the problem was to make it clear to her that she could not manipulate them. One of the

officers had a sister who suffered from panic attacks, and could see that her symptoms were very similar. He eventually requested a mental health evaluation. Over the course of time, with the help of medications and some therapy, the attacks became less frequent and less severe, and she was able to resume normal activities.

* * *

In this chapter, we will talk about mental illnesses that people can develop which result in their experiencing feelings of extreme nervousness and, sometimes, unexplained fear. A certain amount of tension and nervousness in some situations is normal for most people, and sometimes even helpful. This is sometimes called *anxiety*, and is part of our natural reaction to threatening or challenging situations. Before we talk about the problems that can develop when our bodies lose control of anxiety reactions, we briefly will talk about how our bodies normally react when we experience anxiety-provoking situations.

Almost everyone experiences anxiety from time to time. A variety of situations may make us feel nervous. Sometimes these nervous feelings help our bodies respond more quickly and with greater strength when we are faced with some threat to our well being. If someone threatens to hurt us or to harm someone about whom we care, one of the first things that we may notice is a tightening of our muscles, and a quickening in our heartbeat and breathing. This often goes together with a feeling of either fright or anger. Our physical reactions are increased so that we are better able to either run away or to stand and fight, depending on the situation. While this is the most useful part of anxiety, we also can experience these feelings in a variety of situations where the threat or challenge that we sense is not really physical and does not require a physical response.

Most people have few problems naming a list of situations that make them feel nervous or anxious. Some people feel nervous, for example, when they are asked to speak or perform in front of a group of other people. Another time, when many people feel nervous is when they are worried about what could happen to them or someone about whom they care. Many people feel nervous before they take a test or when they otherwise fear the judgment of others about their performance.

For people in the criminal justice system, one example might be the nervousness inmates feel before they go to the parole board for a decision that will affect their life. Being in court is another situation that can cause anxiety. You probably could name many more situations that have caused you to feel nervous. Anxiety is a normal reaction to stressful situations; sometimes, it is useful, and sometimes, it is not. When our bodies and brains are working as they

should, the nervous feelings generally end when the stress or the situation causing the discomfort ends.

An anxiety problem is one of the most common conditions that affect mental health. Anxiety problems are more common than depression. Only problems related to the use of drugs and alcohol are more common. When people develop anxiety problems, their body and brain lose the ability to control anxious or nervous feelings.

The response to stressful situations can become much more intense than normal, causing people to react so strongly that it interferes with their ability to do the things that they need to do. The nervous feeling not only may be stronger than usual, it also might last much longer, in some cases, almost never going away completely. It would be difficult to get much done or to ever be very comfortable if these kinds of exaggerated reactions to stress were present. In some cases, affected persons will feel anxiety without being aware of its source; they may be unable to identify something that is causing them to be frightened or worried.

What are some of the signs that someone's nervous response is more than normally would be expected? We mentioned some of the usual problems that go along with anxiety, such as a fast heartbeat and breathing and muscle tightness. During intense anxiety-provoking reactions, people often feel wired or restless. They may begin to sweat or feel clammy. Their stomach usually feels queasy or actually nauseated. They may feel the need to urinate or defecate more frequently and more urgently, and sometimes, bowel movements may become loose and watery. Hence the expression, "I thought I was going to crap in my pants."

In addition, they may begin to tremble or to feel their muscles twitching, and often they find that it is very hard to concentrate on other things. In some cases, people may feel short of breath and dizzy or lightheaded, or even experience physical pains, often in their chest. Sleep may become difficult during such episodes, and sometimes it is troubled by upsetting dreams.

People may experience several different patterns of abnormal anxiety responses. One of the most confusing patterns is one in which someone experiences a sudden, seemingly unprovoked episode of panic. These episodes sometimes are accompanied by a sense of impending doom and a feeling of unreality, almost as if events were happening in a dream. People may experience extreme physical symptoms and fear that they are having a heart attack and are about to die. These episodes often occur in public places and may cause people who experience them to avoid leaving their home. This pattern is sometimes called *panic disorder*, and when accompanied by a fear of leaving the house, it is said to occur with *agoraphobia*.

Another common pattern of abnormal anxiety is one in which anxious feelings may be experienced on a nearly constant basis throughout the course of the day. These feelings are not associated with any one particular worry or set of circumstances, and while they may be accompanied by worries about specific problems or situations, the amount of worry and anxiety felt is beyond what would be considered reasonable for the conditions. Due to the great amount of energy used by the body when anxious feelings are generated, people who feel this type of anxiety often feel quite drained or fatigued. This pattern is referred to as a *generalized anxiety disorder*.

When people react with extreme fear or anxiety to a specific situation or set of circumstances, it is called a simple *phobia*. Exaggerated fears may be seen in association with a variety of stimuli. Some of the most common phobias include fear of heights, fear of flying, fear of being in small confined spaces, fear of being in crowds, and fear of snakes. These are just a few of many possibilities, however. When confronted with these objects or situations, affected persons will experience a sense of panic until they are no longer confronted with their source of fear.

Another similar condition occurs when people have an exaggerated anxiety response to particular social situations, or a *social phobia*. In this case, the feared situation is related to an activity that must be accomplished in the presence of other people. This endeavor may be public speaking, performing artistically, eating, or doing a number of other activities. As with simple phobias, the response to these situations is an episode of panicky feelings until the threatening situation no longer is present.

The final condition that we will consider is anxiety, and often depression, associated with an extremely stressful and traumatic experience which occurred in the past. This type of problem is called *post-traumatic stress disorder* and commonly is seen in veterans of combat or people who otherwise have been involved in various types of extremely disturbing or horrifying events, such as rape, torture, or situations causing massive loss of life and injury.

In this disorder, people experience three classes of symptoms. The first is *re-experiencing*. This consists of recurrent dreams or flashbacks related to the event. These episodes of re-experience often are associated with the anxious feelings that already were described. The second is *avoidance* or *numbing*. People may go to great lengths to avoid anything related to the traumatic event they experienced, or they may feel very detached from their environment or the people around them. Their emotional responses may be diminished, and they may have difficulty imagining the future. The third class of symptoms is related to having a very difficult time letting down one's guard or relaxing. Persons suffering from this problem are startled very easily, may be highly irritable, and have difficulty with sleep or concentrating on a specific task.

One other problem is related to persons who experience obsessive thinking or feel compelled to perform certain actions to an excessive degree to avoid discomfort, usually in the form of anxiety. *Obsessive thoughts* are thoughts which are unwelcome and unavoidable. People might become obsessed with the idea that they have come into contact with a germ of some type. In the case of *obsessive-compulsive disorder*, they are unable to shake these feelings and may become involved in repetitive behaviors to reduce the amount of anxiety that they feel associated with these thoughts. For example, the person who obsesses about germs, may become involved in repetitive hand washing. This may be such an extreme compulsion that the person is unable to stop this behavior despite its interfering with other activities in his or her life or its making their hands nearly raw!

Obviously, the group of problems discussed in this chapter can be very disabling and uncomfortable. As with the problems discussed earlier, methods of treatment will be discussed in Chapter 8. These types of problems are overlooked easily or minimized in the prison population.

Inmates often are perceived to be exaggerating or fabricating these symptoms, sometimes as a ploy to obtain medications. In many cases, this does occur, so it is especially important to have some idea of how to distinguish between someone who is scamming and the inmate who has a legitimate problem. Although these are not the inmates who are likely to cause you the most problems due to their illness, their suffering can be intense, and this may make their management more difficult than it needs to be.

Other Mental Illnesses 6

Jack was a thirty-two-year-old man who was thin and nearly toothless, and who liked to wear a long scraggly goatee and a bandanna around his head. He had been in and out of lockups most of his life, beginning when he was just an adolescent. He thought of himself as a career criminal, telling the story of many of his exploits with obvious pride. He felt that he was a clever criminal, but that he often was caught due to the stupidity of others he hooked up with, or simply because of dumb luck. He had been involved in many robberies and assaults, and seemed to feel no regret about the people he had hurt in the past. And, he often laughed while saying that they only got what they deserved.

Jack often talked tough. He bragged about what he would like to do to some of the correctional officers if only he were not in prison. He often taunted inmates who were weak or unable to defend themselves, and often would threaten them if they did not do what he asked them to do. He was frequently able to be charming and ingratiating, especially when someone had something that he wanted. He often would make people think he was their friend, only to ignore them after he had gotten what he wanted. He would take what he could get, and did not care how he got it.

He had few contacts outside prison. Outside of his mother and brother, he never had kept a relationship with anyone for an extended period of time. Even his relationship with his mother was a difficult one. He called her a drunk and said that he did not want anything to do with her, anyway. He had been involved with several women in the past, but he always had treated them badly and

eventually abandoned them. He bragged that he had several children, but that he had never seen any of them. He kept on the move, from state to state, from one scam to another, from one jail cell to the next.

By the time he had served the first year of a seven-year sentence, he had made several enemies in the general population and was assaulted and nearly beaten to a pulp one day while out in the yard. After his partial recovery, he was placed in an administrative lockup for his protection.

He began to complain of nervousness and asked to see the psychiatrist. He repeatedly asked for pills to calm his nerves and to help him sleep. Although he suffered no enduring injuries from the attack, he began to complain of pain and demanded medication for that as well. The psychiatrist was not willing to give him medication at first, and Jack responded with challenging questions and finally insults. When the psychiatrist met with the correctional staff, they were able to tell him that Jack's behavior was not consistent with the story he gave to the doctor.

Although the medication continued to be withheld, he would continue to meet with the psychiatrist on a periodic basis, complaining about the prison and several of his "guards," but eventually giving up on really expecting to get medication. He remained in the lockup for many months, and as the prison staff consistently responded to his demands and threats without giving in, his behavior became less annoying and disruptive. When he was released to general population, however, he soon began to recover old behaviors to meet his own needs.

* * *

In the preceding chapters, we focused on a few of the most common mental disorders. While these conditions are those which you will encounter and recognize most often in the prison setting, there are several other conditions which are associated with behavioral problems. These often are more difficult to recognize than some of the disorders we already have discussed, and often more difficult to remedy. In this chapter, we briefly will discuss some of these problems and consider their impact in the prison setting.

The first group of illnesses we will consider is known collectively as *personality disorders*. A personality disorder was illustrated in the opening vignette. While there are specific types of personality disorders, they all can be defined broadly as problems with "living and loving." Persons who are affected by this type of disorder often are known as "difficult people" both in and out

of the prison setting. These difficulties are characterized by trouble in relating to others in a way that prevents stable or long-term relationships and sometimes an inability to get along with anyone for an extended period on a day-to-day basis. In addition, they may have significant problems in controlling their emotional responses and expressions. This often is demonstrated by frequent shifts in mood or by disproportionately intense expressions of anger or distress over what would be relatively minor frustrations for most of us.

These disorders often involve significant problems with behavior, as well. Affected persons may have a great deal of trouble controlling urges to act on immediate feelings, and often are unable to recognize or understand the consequences of their actions. With unstable emotions and an inability to control behaviors provoked by those feelings, it is little wonder that many persons with this type of problem end up in jail. It is also easy to see that persons with personality disorders often are involved in destructive behaviors directed either toward others or toward themselves, so they may be at high risk for violent or suicidal behaviors.

Prisoners affected by a personality disorder often are among the most difficult inmates to manage. They may be demanding and angry much of the time, and of even greater concern, their problems may be episodic and unpredictable. They may provoke or exploit their fellow inmates and, generally, can make the correctional officer's job very difficult and stressful. It is not surprising that correctional officers often feel frustrated and burnt out in a very short time if they are exposed to a population that contains a large number of inmates with severe personality disorders.

What causes this type of problem? No one can answer that question with much certainty, but, it is likely that the roots reach all the way back to early life. There is some evidence that people are born with a certain type of temperament, and that this may influence later personality traits. It also is likely that children develop patterns of interaction with others at a fairly early time in their life.

If children feel safe, protected, and loved on a consistent basis in the early part of their life, it is more likely that they will develop positive and stable feelings about themselves and others later in life, as well. This often translates into an ability to control responses to frustrations and to relate to others in a consistent way, recognizing both their strengths and weaknesses. If this early experience is missing, a person is at greater risk for developing some of these difficulties.

How can we best respond to the problems these inmates present to us? This is not an easy question to answer. These inmates easily can provoke us to anger, and if we are unable to separate our anger from our actions, we can set

ourselves up for further provocation. The inmate will remember our behavior, not their part in producing it. It is most important to act consistently and as fairly as possible. We need to understand that the inmate's anger and behavior really are not attacks upon us personally, but rather are attacks on whom they think we are at any given moment. When we feel that our anger is taking control of the situation, we need to be able to get some distance from the situation and perhaps obtain some assistance from our colleagues, when possible.

Another category of mental illnesses frequently seen in prison settings is disorders of sexual behavior. The most problematic of these disorders are those which involve sexual interest in abnormal subjects such as children or others who cannot engage in consensual sexual activity. These disorders sometimes are known as *sexual perversions*. Any sexual behavior which violates the rights, compromises the will of the subject of that behavior, or attempts to exploit the weakness or naivete of a person can bring a person into conflict with the law, which attempts to protect those persons.

There is some debate about whether persons who engage in such abnormal sexual activity are actually mentally ill, or simply engaging in a criminal activity. While these disorders qualify as mental disorders, behavior associated with them also is considered illegal, and persons who engage in this kind of activity and are caught generally are placed in jails and prisons rather than in secure treatment settings.

There also has been some change in the definitions of "abnormal" over the course of time. For example, up until recently, homosexuality was considered to be a mental illness. Because of the frequency of this type of sexual interest in our society (and others), and because it is a sexual activity generally taking place between consenting adults, it no longer is classified as a mental illness. Homosexual activity is still repugnant to many, however, and is not accepted as a normal variation of sexual preference in all settings. Homosexual practices are very common in the prison setting, often among persons who would not engage in this type of activity in other settings.

Unfortunately, inmates often are forced into homosexual activity even when they do not wish to be involved. Homosexual rape is an abnormal sexual activity just as heterosexual rape is considered abnormal. Rape is a form of sexual sadism, that is, obtaining sexual pleasure from the suffering of another.

While rape is one of the more common and better known of sexual crimes that may result in imprisonment, there are a variety of other compulsive sexual activities, which may have the same result. *Exhibitionism* is exposure of genitals to an unsuspecting person. *Pedophilia* is sexual interest in and activity with children. *Frotteurism* is arousal through touching or rubbing against a nonconsenting person. *Voyeurism* is arousal through watching an unknowing individual

who either is naked or who is engaging in sexual activity. A number of other sexual abnormalities may be observed in the prison setting, although they are not necessarily illegal, and generally are not the reason for incarceration.

Fetishism involves sexual interest in inanimate objects such as certain garments, jewelry, foods, or in some cases, body parts, which would not normally be the focus of sexual attention, such as feet. An extreme example is that of *transvestitism*, where heterosexual persons cross-dress as means to obtain sexual excitement.

Sexual sadism and masochism may take place between consenting adults. *Sadism* involves obtaining pleasure from the suffering or humiliating another. *Masochism* involves obtaining sexual pleasure from being made to suffer or by being humiliated. Ritualistic sexual activity may revolve around various forms of torture or debasement. Several other obsessive sexual behaviors exist, but may not be as commonly seen in the prison setting.

The treatment of sexual abnormalities remains controversial. These behaviors often evoke very strong feelings in many persons, especially if the abnormality involves the exploitation or violation of another person. Whether these conditions should be addressed within the prison setting or in a mental health treatment facility is hotly debated in some circles. There also has been some movement to deprive individuals who engage in these behaviors of their freedom for prolonged periods (beyond their actual sentence) if they have been repeat offenders and if there are reasonable expectations that they will continue to offend if released to the community. Laws to restrict the freedom of these individuals have been passed in some states. The questions raised by such solutions are complex, and the answers to them remain obscure.

As a correctional officer, how can you respond if confronted by abnormal sexual behavior? First, acknowledge that prison is an abnormal situation that may nurture abnormal behaviors. We will gain little by trying to eliminate this behavior, or by taking punitive, judgmental attitudes toward these unusual behaviors. It is, of course, of first importance to protect the rights of inmates who may be the subject of intimidation or under coercion to engage in sexual activity with persons with whom they do not wish to be involved. There are specialized treatment programs which attempt to help sexual offenders control their impulses and sexual aggression, but unfortunately, these often are unavailable in many prisons. For sexual behaviors which do not violate the rights of others, or which take place between consenting adults, attempts to control this behavior generally are limited.

A number of other mental disorders will be mentioned briefly here, since their immediate recognition and treatment are generally not as great a concern as those already discussed. As mentioned earlier, jails and prisons are

extremely stressful situations, and this stress may worsen or provoke already existing mental disorders. Stress may be the source of temporary mental malfunction, as well. One class of mental illness is called *adjustment disorders*. These conditions last for limited periods of time (less than six months) and are directly related to stressful circumstances. Their symptoms may look like depression or anxiety.

In some cases, they may result in behavior which is uncharacteristically aggressive or self-destructive. Persons who have experienced a particularly traumatic event, such as an assault or rape, may experience a mental disturbance related to that event which generally consists of a pattern of detachment. They may appear very withdrawn and emotionally unresponsive, or even dazed. They may describe a sense of experiencing the world around them as unreal or dreamlike. In some cases, there may be a loss of memory for certain events or periods of time. These symptoms may be seen along with feelings of anxiety or fear and, frequently, depression. This pattern of response to severe stress sometimes is called an *acute stress disorder*.

Another group of disorders may result from some type of disturbing event and may serve to prevent those who experience it from having to deal with the painful experiences. These are called the *dissociative disorders*. Here again, persons who experience these problems become detached or disassociated from whom they normally are. The most popularly known of these disorders is *multiple personality disorder*, in which one person may have several distinct personalities, some of which may be unaware of the existence and behaviors of the others.

There is some debate about how common this disorder is, but there are several less dramatic versions in this class. In some cases, a person simply may experience a complete loss of memory of a period of time in his or her life. This may be a period of time in which a particularly distressing event occurred. A more extreme example of this is when a person abandons his or her current life and takes up a completely new identity and forgets his or her previous life. In these cases, persons often wander away from the place where they normally live. When they emerge from this state, they generally have no recollection of what happened during the period of their absence. Treatment of these problems usually consists of helping affected persons to confront traumatic experiences that have brought on these types of occurrences.

Another category of mental disorders sometimes is referred to as the *somatoform disorders*. These illnesses usually involve preoccupation with physical problems. One form of these disorders involves a long history of physical complaints concerning multiple body parts and organs. Despite these complaints, extensive testing reveals no explainable medical cause for the symptoms experienced. These symptoms are not "made up" to achieve some

other goal as in *malingering*, but rather seem to be genuinely experienced. *Hypochondriasis* is another form of abnormality in this category. A hypochondriac has an excessive and unreasonable fear of being sick, usually in some life-threatening way, and this fear persists despite medical assurances that there is no need to be concerned. These persons often do not recognize that their fear is unreasonable or excessive.

The final group of mental illnesses, which we will consider, can be thought of broadly as cognitive disturbances. *Cognition* refers to the thinking or thought processing function of our brains. It includes processes such as memory, attention, and concentration, the ability to understand complex concepts or intelligence, the ability to perform calculations, and the ability to abstract or to form interpretations and generalizations from one or two specific concepts.

Mental retardation usually begins at birth or very early in life and may impair all aspects of cognition, although it is primarily a deficit of intellectual ability. An average IQ (intelligence quotient) is about 100. Persons with mental retardation may have an IQ as high as 70 in mild cases, but it may be below 30 in the most severe cases. Mental retardation causes impaired functioning in many aspects of life, such as communication, hygiene, school performance, ability to work, ability to socialize with others, and generally, the ability to cope with responsibilities and problems encountered in everyday life. It is not hard to imagine that persons with this condition occasionally find themselves in conflict with the law. Persons with mild-to-moderate mental retardation are well represented in the prison population.

Attention deficit/hyperactivity disorder is another type of cognitive disturbance affecting primarily one's ability to pay attention. Because it may impair a child's ability to learn, it may be mistaken for mental retardation in some cases. Generally, it begins early in life, before age seven, and often is associated with hyperactivity or extreme restlessness. It now is known that attention deficits may persist into adulthood and often are associated with problems in making good judgments, decisions, and social functioning. Persons with this problem often have difficulty completing anything they begin and thinking through the consequences of their actions. As a result, they experience difficulties in many aspects of their lives.

In contrast to these disorders which generally begin early in life, *dementia* is a problem that usually begins late in life. We are all familiar with the gradual decline in memory and intellectual functioning that many of our elderly experience toward the end of their lives. To some extent, this is part of the normal aging process, although it is not inevitable. In some cases, however, there may be a more extreme onset and progression of memory impairment in association with deterioration in all aspects of cognitive functioning. This pattern of deterioration is called *Alzheimer's Type Dementia*.

As sentences become more rigid with fewer opportunities for parole, the age of our prison population is increasing and includes a large number of elderly persons. As a result, this type of dementia, which may begin as early as age fifty-five, will be seen much more commonly by correctional personnel. Dementia may occur during other periods in the life cycle, as well. It may result from head injury or other disease processes which affect brain function. One of the most common causes of dementia in prisons today results from HIV infection or AIDS. Severe impairment generally does not occur until late in the course of this illness, but cognitive deficits can be one of the earliest symptoms.

It is worth mentioning here, as we conclude our consideration of various psychiatric problems, that HIV infection afflicts a great number of inmates. It is not surprising, since it is a very common problem in substance-using populations, and this population is one that commonly ends up having trouble with the law. The significance of this fact for our discussion is that HIV infection may affect the brain in a variety of ways, not all of which are well understood. The result is that almost all of the mental health problems that we have described here and in previous chapters can develop as a result of this infection. This is important to keep in mind, especially with inmates without a previous history of mental illness.

Although we have not discussed all the possible forms of mental illness that you may encounter while on duty in a jail or a prison, we have described some of the most common and the most serious problems you will see in these settings. In the next several chapters, we will consider the causes, treatment, and prevention of mental health problems.

The Causes of Mental Illness

7

Mental illness has plagued humanity throughout history, yet there is still great uncertainty about its causes. Over the years, many theories have been suggested and then found to be inadequate. Nonetheless, we gradually are getting a better understanding of mental illness. For example, we know that mental illness is a real, physiological process, and not merely a spiritual or moral affliction. We know that there are many kinds of mental illness, and that many people have or will have a mental illness at some time in their life. We also know that the causes of mental illness are complex and involve the brain, the mind, society, and the environment. Finally, we know that it is possible to treat mental illnesses, and we gradually have become more sophisticated with therapy, medication, and rehabilitation.

People with mental illness often do recover. It is not a life sentence for most people. What is more, even those who remain ill for a long time can live useful and meaningful lives despite their illness. The days when we thought that those who were mentally ill were witches or morally weak or just "acting crazy" are, fortunately, over.

What do we know about the causes of the different types of mental illness? Basically, mental illness seems to be caused by biology and the environment working together. Some diseases, such as schizophrenia, are thought to have a more significant biological basis. Others, such as personality disorders, may have a greater contribution from the environment. The exact mix of biology and environment for each disease, however, is often very uncertain. What follows is a brief description of the way biology and the environment might cause mental illness working alone or together.

In recent years, a lot of research has been conducted on the brain and how it works. We have learned that the millions of nerve cells in the brain connect

together in complex circuits where one nerve cell communicates with another by releasing a chemical into the space between them. Each circuit plays some role in our ability to have perceptions (feel, taste, see, hear, and smell), to think, to have emotions, and to move and control our bodies. If something is wrong with the cells' capacities to communicate with each other, then the circuit does not work. If it is a brain circuit concerned with perceptions or thoughts or emotions, a symptom of mental illness then results.

One piece of evidence which supports this theory is the observation that medications which affect the chemicals in the brain are very helpful in treating a wide variety of mental illnesses. In addition, it is quite clear that alcohol and other excessively used drugs, such as cocaine and heroin, also have large effects on the chemical systems in the brain. These substances seem to have an effect—just the opposite of medications. Their use often leads to the development of symptoms of mental illness.

We also know those medical illnesses such as AIDS or strokes that affect the brain and its chemical systems can lead to mental symptoms. There are other reasons this theory generally is accepted. One is that scientists have discovered that mental illness seems to run in families. This probably means that there is likely to be a genetic component to mental illness. So far, however, no one has found a specific genetic cause for any particular mental illness. There is a great deal of research going on now to find such genes.

The other reason that biological theories of mental illness are popular is that scientists recently have learned how to take special pictures of the brain while it is working. While there are no conclusive findings yet, there is evidence that certain areas of the brain function differently in persons with particular psychiatric symptoms than in persons who do not have these symptoms. The scientific community is very hopeful that we will soon learn much more with these new techniques.

Finally, there is growing evidence that physical and emotional stress affect the brain and the way the brain works. Some scientists think that the concept of stress is a good way to link the brain and the environment together. In this view, social or environmental stress affects the functioning of the brain and can contribute to, or perhaps even cause, a mental illness. This idea is growing in popularity as the effects of trauma and violence on mental health increasingly are recognized.

Repeatedly it has been demonstrated that mental illnesses of various types are much more likely to appear during periods of high stress. For persons who have suffered with mental illness for a long period of time, symptoms and function generally worsen during periods of stress. Many have suggested that the expression of mental illness is dependent on these two factors: biological

predisposition and level of stress. Even persons who have a very high level of resistance to mental illness may develop symptoms when subjected to excessive levels of stress. This has been demonstrated in prisoners of war, torture victims, and survivors of concentration camps. On the other hand, persons who have less biological resistance to mental illness may develop symptoms when experiencing much lower levels of stress.

Sometimes, it is helpful to think about this in a way that is more familiar to us. For example, if we have two rubber bands, one thick (high resistance) and one thin (low resistance), when we begin to stretch them with equal force (subject them to stress), the thin rubber band will break while the thick band remains strong. However, if we continue to stretch the thick rubber band further, it eventually will break just like the thin one did. Clearly, jails and prisons are very stressful places for both inmates and staff. It is very important for all of us to be able to recognize when we are approaching our breaking point, and when those around us may be approaching theirs.

This leads us to consider the environment further, both social and physical, and its effects on mental health. For many years, it has been recognized that what happens to people as they grow up and develop is critical to their mental health. We discussed this briefly in earlier chapters.

How people come to see and understand themselves and other persons is a major part of their emotional lives (their psychological makeup) and may play a big role in how they behave and what they experience. It can determine how well they cope with the problems of living and whether these problems get worse or better. For example, stressors such as conflict in families, traumatic events such as violence and abuse, and social forces such as racism all can have an impact on a person's mental health.

How does this work? It has long been recognized that early life experiences, particularly with primary caregivers, usually parents, can have a significant impact on how persons view the world and the people around them. For example, if children are brought up in an environment which is chaotic, and in which their needs for basic items such as food and being clean are not met consistently, it is more difficult for them to develop into secure and emotionally stable adults.

If children are unable to develop a sense of trust in the people around them when they are young, it will be very difficult for them to do so later. When children's environments are very chaotic, they later may have difficulty forming any meaningful or caring relationships. This often can lead to a disrespect for society in general and isolation from their emotional experience. The result may be behaviors which are heartless and cruel and that appear to have little impact on the person responsible. We often fail to recognize that these persons often are reenacting the experiences of their youth.

Sometimes the environment can have a physical effect on the brain, too. An example of this might be lead from paint, which poisons the brain. Lead poisoning may cause psychiatric symptoms, which are not easily distinguishable from other causes. Other toxins in the environment may cause mental illness as well, so it is important to consider this possibility when someone develops mental problems.

Of course, the most common causes of brain toxicity and dysfunction are drugs and alcohol. Fortunately, in most cases, the brain can recover when the toxin is removed from its environment; however, this is not always the case. Lead poisoning, for example, causes permanent brain damage. Alcohol can cause permanent damage as well, particularly if the brain is exposed to it over a long period of time.

In addition to interacting in causing mental illness, biological, psychological, and social/environmental elements also are involved in the expression of mental illness. A person with mental illness usually experiences changes on the biological level (such as in sleep, appetite, and energy) on the psychological level (including having strange ideas and beliefs, feeling extreme sadness, and craving for drugs) and on the social/environmental level (as seen by disturbed relations with other people or difficulty working). So, even if mental illness is caused by the environment, for example, it has biological and psychological effects and vice versa.

Right now, most scientists agree that biology and the environment (the inside and the outside) interact in mental illness in many ways. What is important for you to know from all of this is that mental illness is not a myth and that it requires biological, psychological, and social/environmental forms of treatment to address its complex "bio-psycho-social" roots and manifestations.

The Biological Treatments of Mental Illness

8

The treatment of persons with mental illness has changed dramatically over the years, just as theories and beliefs about mental illness have evolved. In ancient days, persons with what we would now call a mental illness might be considered to be "touched" by the hand of God and revered or to be doing the work of Satan and cast out or burned.

Over the course of centuries, persons with mental illness have been viewed in various ways by society, and this has resulted in different approaches to their treatment. On one extreme, persons with mental illness have been removed from community life and placed in asylums or prisons. On the other extreme, people who suffer from these illnesses have been viewed as part of the community, and have been housed and cared for by family and the community.

Over the past two centuries, people with mental illness have been treated in hospitals for the most part, and only recently have there been attempts to integrate persons with mental illness back into the community. Unfortunately, adequate supports have not always been available in communities, particularly in this age when family and community structures are not always well defined. This partly has been responsible for the large number of persons with mental illness who end up in our jails and prisons, once again removed from our communities.

Several forms of treatment have been used to stop mental illness. Some forms of treatment, like a lobotomy (an operation removing part of the brain) or bleeding, fortunately have come and gone. Others, which have been more humane or effective, have persisted and even grown. Currently, there are three major approaches to treating mental illness: (1) the use of medications and other "biological" interventions like electroshock therapy; (2) psychotherapy or "talking" treatment; and (3) rehabilitation or "doing" treatment.

In this chapter, we will be focusing on the biological types of treatment. Remember, most mental health professionals agree that each mental illness and each person with a particular mental illness requires an individualized approach. This means, for example, that what works to treat an illness like schizophrenia (a form of psychosis), does not work to treat addiction, and that the specific treatments used for one person with schizophrenia may not work for another with the same disease. In short, like the illnesses involved, treatment is complex, and usually involves all three of these methods. The other two methods of treatment, psychotherapy and rehabilitation, will be considered in the next chapter.

The point of the following section is to acquaint correctional officers with some basic information about biological treatments often used with persons who have mental illnesses. The correctional officer can play an important role in identifying inmates who may be having problems, and monitoring their progress after treatment has been initiated. This function will be supported by some knowledge of the types of medications which are available to address these problems. The correctional officer often knows the inmate better than anyone else in the system. The information you provide to mental health workers is often as valuable, and often more valuable, than what they can obtain by themselves with direct observation for short periods of time.

Be aware that the treatment of inmates for mental health problems is evolving across the country and varies from place to place. Unfortunately, in some jails and prisons, the lack of treatment is still quite common (that is one of the reasons we are writing this book). This lack of available treatment sometimes has resulted in lawsuits against certain correctional systems on behalf of prisoners with mental illness.

Psychotropic Medication. A psychotropic medication is a medicine that has major effects on behavior, thinking, or feelings and usually relieves some kind of unpleasant experience. These medications must be prescribed by a physician. Sometimes, people are confused about the difference between "medications" and "drugs." After all, both are "psychotropic" in that they affect the brain. Recognize that *drugs* refer to self-administered substances that may alter behavior or mood. They generally have some pleasurable effects which have a rapid onset and reinforce use, and they usually are illegal (except for alcohol). Importantly, these drugs generally cause their users to have a high potential for addiction or dependence.

Medications, on the other hand, usually do not have any immediate effect on the brain, but rather have a gradual effect on behaviors and mood. They do not produce a "high" in the same way that drugs do. Medications, generally, are prescribed by a physician and usually do not have any value on the street.

There are a wide variety of psychotropic medications used to treat mental illness, but they fall into a few basic categories: Antipsychotic medications are for psychotic illnesses and commonly are known by their trade names (such as Haldol, Navane, Trilafon, and Thorazine). Antidepressant medications are for depression and anxiety (Prozac, Tofranil, and Norpramine). Mood stabilizing medications do what the name suggests—stabilize mood (lithium, Tegretol, and Depakote). Sedatives and "antianxiety" medications are prescribed for agitation and nervousness (Valium, Ativan, Restoril, and so on). These medications work by correcting a presumed chemical imbalance in the brain.

A number of common issues bother people regarding medication. These include side effects (specific to the type of medication used). Other issues include feeling stigmatized or being treated poorly because of taking medications. Another big issue is remembering to take medication. Unfortunately, many of the medications have to be taken every day—sometimes, several times a day.

Antipsychotic Medication. There are many reasons for taking antipsychotic medications. These include experiencing the symptoms of psychosis, such as hallucinations (seeing, hearing, or feeling things that are not there), having delusions (believing things that seem bizarre to everyone else), and experiencing thought disorders (having difficulty being coherent and clear). Antipsychotics also are used to control agitation and potential violence. For this reason, these medications are called *major tranquilizers*, as well.

These medications come in a variety of strengths. Some, like haloperidol (Haldol) and fluphenazine (Prolixin), are very strong and only a small amount of medication is necessary. Others are weaker, such as chlorpromazine (Thorazine), thioridazine (Mellaril), and mesoridazine (Serentiyl) and require dosages of several hundred milligrams each day. Finally, some are in the middle. These include perphenazine (Trilafon) and loxapine (Loxitane). A more complete listing of these medications, their chemical name and brand name, and their potency can be found in Table A-1 (*see* page 85).

The side effects of these medications often are troublesome and depend on the strength of the antipsychotic used. In general, the strong medications can cause stiffness, restlessness, tremor (shakes), dystonia (muscle cramping), and weight gain. The weaker medications cause dry mouth, blurry vision, urinary retention, constipation, periods of low blood pressure (fainting), fatigue and sleepiness, and problems with sexual functioning (difficulty having an orgasm or loss of interest in sex). Medications in the middle level of strength can cause side effects from both categories.

All these medications can cause a movement disorder called *tardive dyskinesia*, especially if high doses are maintained for a long time. Sometimes other medications are used to combat these side effects, especially stiffness and

muscle cramps. These include benztropine (Cogentin), trihexylphenidyl (Artane), and propranolol (Inderal).

Several new medications which do not cause the same degree of side effects recently have been developed. These include clozapine (Clozaril) and risperidone (Risperdal). Unfortunately, clozapine sometimes can damage the body's ability to make certain blood cells. Therefore, anyone taking it must have a weekly blood test. Sometimes, the risk and inconvenience are worth it because clozapine often works when other medications have not. Risperidone also appears to cause fewer muscular side effects, but it is not certain that it works well against psychoses that do not respond to common antipsychotics. Many new antipsychotics are being developed which have a great deal of promise, but they have not yet been approved for use in nonexperimental conditions.

How long these medications should be taken depends on the illness. Sometimes it is necessary to take them throughout life. The goal of treatment is to relieve the symptoms of psychosis while having minimal side effects, using them at the lowest dosage possible and for the shortest time possible. Some of these medications can be taken by injection every few weeks, but most of them must be taken by mouth (pills or liquid), usually once a day before bed.

Antianxiety Medications. Antianxiety medications include a variety of substances referred to as *benzodiazapines* and buspirone (Buspar). These medications help people feel less anxious, and they sometimes are used to help people fall asleep, as well. Unfortunately, the benzodiazepines (including diazepeam, alprazolam, chlordiazepoxide, lorazepam) also can be addictive, so their use in jails and prisons is highly controlled. Buspar is not addicting, but it takes a longer time to work. These medications may be taken while a person is under stress, but they sometimes are needed for the conditions described in Chapter 4, "Problems with Thinking."

For persons who experience constant anxious feelings or panicky episodes, these medications may be helpful. Physicians prescribing such medications need to be very careful, however, since inmates have been known to report symptoms in order to obtain them. Once obtained, these medications may be diverted for sale, and technically become "drugs." A complete listing of the various antianxiety medications, their potency, and the major use of each is contained in Table A-2 (*see* page 86).

Antidepressant Medications. Antidepressants are used to treat depression, obsessive and compulsive behavior, post-traumatic stress and, sometimes, insomnia. There are now a large number of different kinds of antidepressants. The first antidepressants were developed about thirty years ago. Amitriptyline, imipramine, and desipramine are some of the older medications that are still

in use. They cause a variety of side effects—fainting, dry mouth, constipation, weight gain, and sedation. They also can be dangerous for persons who have trouble with their heart. These medications are being used less frequently today as newer agents have become available. They still are effective, however, and often are used because they are economical and can be helpful when symptoms such as poor sleep or anxiety are present. Trazodone (another kind of older antidepressant) also often is used for problems with sleep.

The newer antidepressant medications such as fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), and venlafaxine (Effexor) are being used much more frequently today because they cause fewer side effects and work just as well as the older antidepressants. They are less likely to cause weight gain and are less dangerous for persons with other medical problems. However, they are not problem free. They sometimes cause nausea, nervousness, and sleeplessness. Frequent difficulty having an orgasm also has been reported. These medications usually are taken in the morning so as not to interfere with sleep. Like the older antidepressants, they have to be taken daily, and they take a while to work—sometimes up to four to six weeks. Once someone starts an antidepressant, they probably should take it for a year or more after their symptoms go away. A full listing of the antidepressants is shown in Table A-3 (*see* page 87).

Mood-stabilizing Medications. Mood stabilizing medications are used by people with manic-depressive illness (bipolar disorder), psychotic illnesses when they are associated with an unstable mood (agitation, irritability), and psychotic illnesses which do not improve with the use of antipsychotic medication alone. These medications include lithium carbonate, carbamazepine (Tegretol), and valproic acid (Depakote). Of these, lithium is the oldest and most commonly used. It may be the most effective, also. A full listing of medications used for stabilizing mood is presented in Table A-4 (*see* page 88).

Each of these medications produces different side effects. Lithium often causes increased thirst, increased urination, diarrhea, tremor, lethargy, weight gain, poor concentration, occasional sexual dysfunction, and nausea. This is especially so if the dosage is too high. Carbamazepine can produce sedation, nausea, and vomiting. Valproic acid sometimes causes nausea and sometimes sedation, but otherwise, it is tolerated fairly well. Propranolol and clonazepam sometimes are used to control the tremor associated with lithium treatment, and clonazepam can be very helpful in controlling mania until other medications become effective (usually four-to-ten days). Usually these medications are taken for a long time, partly because they seem to prevent mood swings as well as treat them. All require blood monitoring every month in the beginning, then less often, to assess the levels of the medication in the blood. These medications all are taken by mouth, sometimes several times a day.

Please note that the dosages indicated in the Tables A-1-A-4 represent the most common recommended dosages, but all of these medications may be used in dosages outside those ranges in some cases.

Although most modern "biological" treatment uses medication, which is taken orally, one exception that still is used commonly is *electroconvulsive therapy* (ECT). This treatment was, in fact, one of the first biological treatments and has been used in various forms since the 1940s. It was developed in response to the observation that epileptic-type seizures seemed to interrupt mental illnesses on at least a temporary basis. A variety of methods of causing seizures were attempted, but electrically induced seizures eventually emerged as the safest and most effective method.

ECT has been used for a variety of mental problems, but today it is used most commonly for severe depression, which does not respond to medication. It also has been shown to be quite effective in manic depressive illness and in some cases for schizophrenia. Typically, an episode of treatment consists of five-to-ten induced seizures usually given no more often than every other day. In some cases, a slightly longer course might be recommended. The seizures are administered while patients are under anesthesia with complete muscular relaxation, so while a seizure is induced in the brain, it is not evident as a typical epileptic seizure would be. As with medications, it is thought that ECT exerts its effects by restoring normal chemical balance to the brain, although the exact mechanism by which this is accomplished is unknown.

Despite the effectiveness and safety of ECT, it has not enjoyed a good reputation with the public and, in many cases, with the medical community. There are several reasons for these negative perceptions. Historically, when ECT was first discovered, there were few treatment alternatives, so it sometimes was used indiscriminately and ineffectively. In the early days of its use, patients were not completely anesthetized, and the treatments were therefore more dangerous and often were seen as cruel. Even though these early problems mostly have been eliminated, these associations have persisted in the public's mind. A second factor that has caused some fear about ECT is the fact that it often causes some short-term memory impairment that may last up to six months. There is strong evidence showing that there is very rarely any permanent thinking difficulty.

However, a very small minority of persons who have experienced ECT report longer term, although minor, memory impairment. It is not known whether these complaints actually are related to the ECT treatments or to other factors, but they, nevertheless, have contributed to some of the negative perceptions about ECT. Despite these concerns, ECT has been used more commonly again in recent years and is seen as a very useful and rapidly effective treatment for certain conditions, particularly if medication has failed or cannot

be used due to pregnancy or other medical conditions. In many cases, it has been life-saving.

Mixing *medications and drugs* sometimes can be dangerous, particularly when the user knows little about how these substances work in the body. The effects produced depend on the type of substances being mixed. Sedating drugs (such as alcohol, pills, and opiates) when mixed with antipsychotics, antidepressants, mood stabilizers, or antianxiety medications may cause increased sedation and even overdoses. Stimulant drugs (amphetamines, cocaine, and caffeine) may counteract sedating effect of antipsychotics and lithium for a brief period. At the same time, using stimulants may place high demands on the cardiovascular system (heart and circulation), may make the user feel anxious, and may counteract the protective effects of antipsychotic medication. Hallucinogens (marijuana, LSD, PCP) may counteract the stabilizing qualities of psychiatric medication and make one more vulnerable to mood swings and to psychosis.

No matter what kind of medication is being used, there are two basic principles to keep in mind. First, taking medication *as directed* is very important if it is to work correctly. Second, it is very important for all patients to learn about the medications they are taking and to talk to the doctor about them, asking questions and saying how the medication affects them for better or for worse.

Nonmedical Treatments of Mental Illness: Psychotherapy and Rehabilitation

9

When most people think about psychiatry, they tend to imagine the psychiatrist as a psychotherapist. The image of a psychotherapist sitting behind a couch, listening to a patient who is lying on it, is a common stereotype. It comes from the heyday of psychoanalysis, one of the original psychotherapies invented almost a century ago by Sigmund Freud. Since that time, psychiatry and psychotherapy have changed a great deal. Although many psychiatrists continue to do some psychotherapy, now they also use medications.

Psychotherapy has developed many new forms since its early days, and psychoanalysis as Freud practiced it is rarely done today. This chapter briefly will review the major types of psychotherapy in use today. In addition, the concept of psychosocial rehabilitation will be introduced. The chapter concludes with some comments on the "psychotherapeutic" role of the correctional officer.

The original purpose of psychotherapy was to help individuals who experienced psychological distress. This included reducing strong feelings of anxiety, depression, or fear that they experienced in daily life. As time went on, other uses for psychotherapy were developed. It was used as a way to actually help people change their personality or character if it was in some way disagreeable. It was claimed that people could change their behavior and disposition so that somebody who was loud and insensitive might become more considerate, for example. Persons who were angry and demanding might learn how to feel more at ease with themselves and others.

In more recent times, the goals of psychotherapy have developed further, and in many cases, are somewhat less ambitious. Today, psychotherapy often attempts to help people learn to deal with the stress that they experience in their daily lives and helps them resolve the problems that they struggle with day to day. It attempts to teach new skills for managing the demands of daily life. With

this new emphasis on the development of better coping skills, a new approach to persons who are disabled by mental health problems has developed.

The concept of rehabilitation is based on the notion that persons who have various kinds of disabilities need to learn how to reach their full potential and participate in society as fully as possible, despite their limitations. In the following pages, the various types of psychotherapy and rehabilitation that currently are being used in mental health practice will be discussed. Before doing that, it would be a good idea to note some of the common themes that occur in almost all of these psychotherapeutic processes.

Many scientists have tried to discover how psychotherapy works or even if it works at all. Given that there are a number of different approaches to psychotherapy, it is not surprising that people are interested in investigating which of them seem to work best. For the most part, the results tend to indicate that there is not a great deal of difference in the effectiveness of the various types of psychotherapy. That has lead some investigators to look for the common qualities that exist in all of these approaches.

What they have discovered is that all psychotherapies are built around a therapeutic alliance or, put another way, built around a relationship. In that relationship, a patient and a psychotherapist agree to work together to achieve some goal or to solve some problem. The psychotherapist is the patient's ally, someone who is concerned about his or her welfare, who pays attention to him or her, and who listens. Another common element is that the relationship and the interaction between these two people provides some structure and meaning in the patient's life.

Finally, another common characteristic of psychotherapies is that these approaches all require a certain amount of discipline on the part of the patient and the psychotherapist. That means that the patient and psychotherapist are in the process of focusing on particular problems over a period of time. This action, itself, may be enough to reduce some of the distress persons feel when they face those problems alone. For many persons, the simple process of expressing their thoughts and feelings in an atmosphere where they do not feel threatened or judged can provide tremendous relief.

Probably the most common type of psychotherapy is individual psychotherapy. That means that a patient and a psychotherapist meet and talk with each other at set intervals, usually about once a week. The understanding is that the psychotherapist is there to listen to the patient and attempt to help that patient understand the problems and the symptoms that made the patient seek help in the first place. As mentioned earlier, psychotherapy had its real beginnings with the work of Sigmund Freud and his colleagues. Many people are familiar with the concept of *psychoanalysis* in which a patient lies on a couch

and the psychoanalyst sits behind while the patient is encouraged to "free associate." This means that the patient is supposed to say whatever comes to mind and the job of the psychoanalyst is to understand and make connections between the things the patient says. This process is very lengthy with patients sometimes spending many years "on the couch" seeing the psychoanalyst on an almost daily basis. It still is practiced in some areas of the country but, now generally, is confined to people who are very wealthy, because it is very costly. It is also not clear whether psychoanalysis is effective enough to justify its cost.

While psychoanalysis is not practiced very much any more, large numbers of psychotherapists use some of the principles derived from psychoanalysis in doing what is termed *psychodynamic psychotherapy*. This kind of therapy involves meeting with a patient on a regular basis, up to two times a week, for an hour or so. The patient faces the psychotherapist and discusses issues that are troubling to him or her. The job of the psychotherapist is to help the patient think about how he or she can understand the problems or distress he or she wishes to reduce. It may be that the therapist helps the patient solve his or her own problem simply by asking the right questions. The theory is that if patients have a way to understand why they are suffering, they can begin to change. There is some uncertainty as to whether this method is effective in helping people make the changes they are trying to achieve, and if it is, whether the same goals could be accomplished more quickly and economically. Nevertheless, most psychotherapists in the country learn this kind of therapy as the basic way to understand psychological processes.

When psychoanalysis and psychotherapy were first used, they were used primarily with persons who were able to think clearly and abstractly. Most experts doubted that it could be helpful to persons who had severe and persistent mental illnesses like schizophrenia. The thinking was that these individuals were not able to tolerate the stress that often preceded the "cure," and that they did not have the mental capacity to understand their problems. As a result, in the last thirty years or so, a new type of psychotherapy has developed which does not require the same kind of intellectual resources. This type of psychotherapy is called *supportive psychotherapy*. It is a problem-focused approach to helping individuals with severe and persistent mental illness learn how to cope with the problems that they encounter in their lives and the symptoms that they experience. In this type of therapy, the relationship with the psychotherapist remains very important. It allows patients to feel that they are less isolated and alone. The techniques of supportive psychotherapy include listening, working to understand what a person is trying to convey, offering supportive or encouraging comments, and helping individuals solve problems that they confront. Supportive psychotherapy probably is the most common type of psychotherapy practiced in mental health settings today, particularly with persons with severe and persistent mental illness.

Another type of psychotherapy is one which some might not call a psychotherapy at all. It is called *psychoeducation*. Psychoeducation is a relatively new approach to helping individuals with mental illness learn how to cope with the illnesses that they have by teaching them about their illness and how other people have successfully lived with it. This kind of psychotherapy requires the therapist to be much more active and is not focused on the patient's thoughts or feelings.

In the last twenty years or so, there has been an increasing focus on the development of brief psychotherapies. The idea of *brief psychotherapy* is that long periods of time in treatment are not always required for some people to experience relief. Brief psychotherapy was developed in order to use psychotherapy to address more specific problems than was commonly the case in traditional types of psychotherapy. There are several variants of brief psychotherapy, but most of them try to determine a specific event or situation that has been the source of distress for the patient. By using a narrower scope, brief psychotherapy attempts to deal with the immediate problem. No effort is made to change personality or to teach a wide range of coping skills.

In recent times, other kinds of psychotherapeutic approaches have been developed. One type, which is, again, much different than traditional psychotherapy, has become quite popular and is effective for a variety of problems. It is called *behavioral therapy*. This is a process in which individuals are rewarded or punished for behaving in particular ways. An example of this is a behavioral program in which people are rewarded for completing specific activities, such as attending a group, and are not rewarded when they do not. The thought is that by shaping people's behavior in this fashion, the problems that caused them to come in for therapy will decrease.

One variant of behavioral therapy is *biofeedback*. With this method, people learn to recognize biological cues, such as rapid heartbeat or falling blood pressure, as a signal for oncoming anxiety. Recognition of this state, initially through the use of various monitoring devices, allows individuals to use behavioral changes to alter the course of a distressing event or thought. Patients are instructed to focus their thinking on something pleasant and relaxing rather than fixing on their fear and anticipated discomfort.

More recently there has been a lot of attention paid to cognitive psychotherapy. *Cognitive psychotherapy* often is used in conjunction with behavioral therapy and is based on the idea that individuals with psychiatric disturbances have abnormal ways of thinking about things. The theory is that if the way that they think causes their discomfort, then changing the way they think about things should produce relief. An example might be that persons who are depressed feel like they have let everybody down throughout their lives. A cognitive therapist would work to help the individuals reshape that

thought and to examine whether it is really true. In most cases, patients will realize that even if they had let some people down once in a while, the truth was that they had not let everybody down all of the time. From here, the therapist helps the patients to recognize some of the good things that they have accomplished. Cognitive therapy has been used in both short- and long-term therapy and is increasingly popular.

Another variant of individual psychotherapy is *interpersonal therapy*, which is an effort to look at the relationships that an individual has and how they determine or influence the emotions and behavior of that person. The interpersonal therapist helps patients understand their relationships with others so that they can interact with the people they care about in a more positive manner.

Another approach to psychotherapy has been to work with groups of people rather than individuals. *Group psychotherapy* has become a very common and very popular kind of therapy. There are a number of different approaches to group therapy just as there are for individual therapy. As a general rule, group psychotherapy occurs for an hour to an hour and a half once or twice a week. The size of the group may vary, but groups composed of five-to-fifteen members are most common. The group provides an atmosphere in which the participants can relate their own individual experiences and also can listen to those of others.

Listening to the experience and concerns of others can be helpful in understanding one's own problems. The interaction between group members may provide clues about the interpersonal difficulties that group members are experiencing and which may contribute to their distress. The job of the group leader is to help structure the conversation and to encourage interaction and participation of all group members. The leader may respond to individuals in the group but also might help the participants to understand how their behavior and unspoken expressions create another form of communication that finds life only in the group. Multiple relationships are created by the group rather than the single one discussed when we considered individual therapy. The therapist often remains in a position of great importance, but the participants also have an important impact on the process of change and the creation of meaning and discipline mentioned earlier when the common elements of individual psychotherapy were considered.

An additional element of group psychotherapy is that individuals develop a sense of belonging in the group and a sense that they play a role that goes beyond themselves. This aspect of group interaction has been used effectively in recent years with the increasing activity of mutual aid or self-help groups such as Alcoholics Anonymous, Recovery, Inc., and a variety of other groups which are geared toward helping people deal with problem behaviors and emotional distress. These groups function without having a professional group

therapist as a leader and appear to be very effective for many people who participate in them.

A variant of group therapy is *family therapy*, which focuses on how individual members of the family relate to each other and understand each other. This kind of therapy, while rare in jails and prisons, is a fairly common therapy out in the community, and is important to note because it emphasizes the importance of family members in the emotional life of individuals. It certainly has taught individual and group psychotherapists that what is happening with families provides critical information that needs to be discussed in psychotherapy. Individuals' experience and interaction with their family is an important determinant of how they interact with others as an adult. It also may have a significant impact on how they experience themselves and their world.

As mentioned earlier, supportive psychotherapy for persons with psychiatric disabilities is a very common type of treatment. It has become clear that rehabilitation offers something in addition to providing emotional support in problem-solving. Persons with psychiatric disabilities also can benefit from their participation in activities that teach them coping skills. For example, meeting with someone and giving advice about how to solve a problem in an office usually is not as helpful as it is to actually go to where the problem is. An example would be going to a supermarket and helping someone figure out how to cope with crowds, budgets, and choice of which kinds of food to eat. Similarly, it often is useful to provide support and assistance while a person is in the process of learning. That may consist of being with them on the job or in their apartment. There is increasing evidence that these kinds of skills can be taught most effectively when they are taught in the settings in which they occur.

The development of psychiatric rehabilitation has created a great deal of hope for people with psychiatric disabilities. When they are offered *psychosocial rehabilitation*, these people are able to improve social skills, educational skills, and vocational skills. They can learn new ways of coping with severe mental illnesses which often can be disabling despite all other efforts to neutralize its effects.

Having described psychotherapy and rehabilitation, it is important to think about how these kinds of therapeutic interventions can be used in jails and prisons. Unfortunately, resources often are limited. The availability of psychotherapists to treat prisoners in psychotherapy tends to be insufficient. Nonetheless, it should be clear that from all the evidence that we have, efforts to understand the emotional concerns and problems of an inmate are worth making, and it is possible to adapt some psychotherapeutic principles to working with inmates on an individual level. Much more likely, however, and easier to imagine, is a mix of supportive psychotherapy, group therapy, supervised mutual aid activities, and rehabilitation activities in jail and prisons.

One hope for the future is that increasing awareness of the importance of psychoeducation and psychosocial rehabilitation will lead to a greater availability of these services in jail and prison. If individuals can learn new techniques for coping with their disabilities while in jail or prison, they would have a much better chance of surviving in the community after they are released. Hopefully, these skills would allow them to avoid returning to the corrections setting.

Some of the approaches to psychotherapy may seem somewhat familiar to you as a correctional officer. For example, the concept in behavioral psychotherapy of rewarding individuals for particular kinds of behavior and punishing them for other kinds of behavior certainly will not seem strange to any correctional officer. *Psychotherapy*, on the other hand, and the concept of trying to understand the emotional life of an inmate may seem somewhat more difficult and problematic.

However, it is important to realize that the correctional officer who is able to listen in an understanding way to an inmate is much more likely to be able to anticipate the concerns of that individual and to be able to address them in the most appropriate way possible. Being in a position to have inmates talk from the heart to a correctional officer probably is one of the most useful things a correctional officer can do to help individuals come to grips with their psychiatric and emotional distress. Understanding mental health problems will make you much more effective in managing problems that you will commonly encounter in your role as a correctional officer.

Having said all this, it is important to realize that correctional officers have a particular job to do, which is to manage confined individuals who have been accused and convicted of a variety of different kinds of crimes. This confinement often is viewed as punishment rather than rehabilitation. In that role, correctional officers are going to find themselves subjected to a great deal of hostility, so it would not be wise to trust entirely what inmates may tell you. It is important to maintain a healthy distance and a skepticism regarding the motives of inmates and to be in a position to make appropriate judgments about the sincerity of what inmates report. The best approach is to maintain a healthy balance between understanding and concern on one hand, and keeping a watchful eye out for ulterior motives on the other.

Inmates may bring certain expectations with them about their relationships with correctional personnel. As we have seen, trust is an important condition that allows counseling to happen. It often will be difficult for correctional officers to establish themselves as trustworthy and sympathetic figures without compromising their ability to maintain order and discipline. Nevertheless, for the inmate who is clearly distressed and vulnerable, the supportive presence of the correctional officer sometimes can make all the difference.

This chapter discussed some of the ways that persons with mental health problems can be helped in the prison setting, and we briefly considered what role the correctional officer might play in providing assistance. In the next chapter, we will take a look at your mental health and how you can help preserve it in a very stressful environment.

Preventing Mental Illness

10

Dave was forty-eight years old and had been working in the prison system for over twenty-two years. He was a sergeant working on the self lock-up unit, and he took pride in his job and his ability to work with the inmates. He was respected by his fellow correctional officers and by the inmates who felt that he treated them fairly, and he did not misuse his power over them. His coworkers respected him because he did not use his administrative responsibilities as a shield to avoid interacting with the inmates or otherwise pitching in when needed. He had a family he enjoyed with a daughter in college and a son entering adolescence.

Things began to change when the prison gradually became crowded with stiffer mandatory sentences and decreased opportunities for parole. This seemed to bring a new breed of inmate, more combative and disagreeable, who knew that their good behavior would not reduce their sentence. That is what Dave thought, anyway. He began to feel less satisfied by his interactions with the inmates. His coworkers began to notice the change; he was not as involved or active, but they thought that it would pass. As the problems within the prison worsened, problems began to develop at home, as well. Dave's son began to stay out longer than he should have; he began to neglect his studies and his grades fell. Dave began to get into conflicts with him and tried very hard to change the behavior by withholding some of his liberty and scolding him to get his act together. He had little success, however, and his bickering with his son soon affected his relationship with his wife, who thought he was being too hard on the boy. Dave found himself

drinking more beer than usual in the evening. It seemed to allow him to calm down and sleep.

Things did not improve as time went on, and Dave often would wake up tired and dreaded going into work. His stomach felt unsettled, and he had no appetite in the morning. He felt irritable, and this began to show itself on the job, especially in his interactions with the inmates. His reputation began to change. The inmates now complained that he was rigid and verbally abusive to them. Several made threatening remarks to one another about how they would get him back if they had a chance. His coworkers began to avoid him as well, since he did not seem to want to talk to them about anything other than what they were doing wrong. A couple of his old buddies tried to find out what was wrong, but he insisted that he was all right, it was just this "new breed" of inmate that was getting to him a little bit. He thought they needed a firmer hand.

Behind this facade, Dave began to realize that something was not right and that he felt miserable and desperate nearly all the time. He was afraid and ashamed to talk about it though. He felt that it would make him seem weak and that he would lose respect. Most of all, he felt that if he talked about it, it would become more real, and he desperately hoped that it was just a nightmare that would come to an end. He lost interest in the things that usually kept him busy and made him happy, and he struggled to get through his day and face his responsibilities. His drinking became more intense, and it seemed to be the only way to numb his misery. He was drinking six to eight beers each evening instead of one or two, as in the past. His conflicts at home grew worse, and his wife, at her wits end, told him he needed to get some help. This made him furious, and he stormed out of the house. He called in sick the next day and spent most of the day drinking. When he awoke in a strange place, he knew that he had reached the end of his rope. He thought of ending his life and his misery, but he was too frightened to let himself think about it too much. He knew though, that if he did not follow his wife's advice, and if things did not improve, there would be no future.

Dave managed to get himself cleaned up, and he went home where his wife was waiting for him. He felt like crying, and it took all his strength to hold back the tears. He began to talk to his wife that evening, telling her that he did not know what had happened, but that everything in his life had become dark and empty. He told her that he knew there was a program at work for guys who were

having trouble. He had suggested it to several of his men in the past, and although he never asked them about it directly, things started to improve for them. He promised her that he would make an appointment the next day.

* * *

It is important to be aware of the emotional stresses that correctional officers face in doing their job in a jail or prison setting. This story is all too typical of what many correctional officers experience at some time during their careers. As we have seen, mental illness can affect everyone, and the correctional officer is no exception. In fact, due to the high amount of stress they face on the job, mental illness may be much more common among persons who work in this environment. Unfortunately, the correctional "culture" discourages correctional officers from revealing their own stresses and strains and emotional feelings for fear of appearing weak. It must be recognized that in many situations, this is a reasonable fear. Inmates may try to take advantage of perceived weaknesses, fears, or lack of confidence. Correctional officers must be able to distinguish when and with whom they can confide the difficulties they encounter in doing their job and know how to get support from and give support to colleagues.

To protect your own mental health in the correctional setting, one of the first prevention concepts to employ is developing the ability to identify stressors on the job. There always will be situations that arise unexpectedly that little can be done to eliminate, but there frequently are a great number of factors causing stress that can be reduced by changing systems or procedures being used. For example, if certain procedures or rules are too rigid or unreasonable, they will create a great deal of resistance and confrontation. These situations are highly stressful. On the other hand, if a situation is not structured enough and expectations are not clear, a great deal of confusion and chaos may result, and attempts to reestablish control also can be very stressful.

Clear, consistent procedures and expectations which are uniformly enforced will provide the calmest environment for all involved. Teamwork is essential, and some mechanism for solving problems that are identified can go a long way toward maintaining a healthy work environment. Regardless of efforts to maintain stress at minimum levels by providing adequate staffing levels and avoiding crowding for example, there will be instances when situations arise which can be frightening or dangerous. It usually is very helpful for officers to have an opportunity to express themselves openly after the event. Talking about these feelings often can relieve the tension created by holding them inside or by pretending that they do not exist. Nine times out of ten, other officers will have experienced the same feelings that you had during an uncontrolled event. It is important to have a work environment where it is

"safe" to talk about fears or other uncomfortable feelings without concern about ridicule or loss of respect.

The corrections environment is not the only source of stress in most correctional officers' lives. There can be problems at home, or with finances, for example, that may create discomfort and require significant energy for coping. When these problems arise, particularly when circumstances are stressful on the job, sometimes our coping skills can be overwhelmed. This may result in an inability to function as well as you normally would in all spheres of your life. When these problems start to occur, they can make you very vulnerable and less capable of fulfilling your responsibilities. It is important to recognize the warning signs of developing difficulties early so that they can be arrested before your disabilities become more serious.

The story at the beginning of the chapter shows how problems can progress if they are ignored or denied. There were several indications early on that Dave was developing a problem. He began to feel less positive about his job and the persons with whom he was working. He was more irritable and began to interact differently with inmates, fellow officers, and family members. He began drinking much more than he usually would. If he had contacted his Employee Assistance Program at this early point, he may have been helped to avoid some of the more serious problems he went on to develop. Failing to recognize these problems pushed him into a downward spiral of events and actions which caused him a great deal of misery and probably put him in considerable danger of being involved in an incident on the job. Early recognition of warning signs of approaching illness will protect not only your health, but your safety, and that of your coworkers.

In addition to creating an atmosphere on the job which does not create undue stress, providing opportunities for discussing critical events, and being vigilant about possible indications that trouble is developing, it is important to develop healthy personal habits and strategies for managing stress. Whatever the source of stress, it is important to develop ways to "unload" it so that it does not have an opportunity to become a growing burden. Exercise and rest are two factors which may play a significant role in reducing your "burden" of stress. Many people find that exercise is an effective and healthy way to relax and release tension. Getting the proper amount of rest also will increase your capacity to cope with stressful circumstances.

Some people obtain "rest" through meditation. There are many different forms of meditation, but the common principles seem to be uncluttering the mind, relaxing the body, and slowing down mental and physical processes. Another obvious way to get rest is to develop good sleep habits. People develop a variety of other ways to "unwind." Recreational interests and hobbies are one way to get a vacation from pressures on the job or in your personal life. It

is always helpful to have a wide variety of interests and activities to select from when you have free time.

Unfortunately, those who have not developed healthy personal habits of exercise, rest, and recreation, often look to other sources for relief of tension. This often takes the form of alcohol or drug use. People often state that drug use problems began as a way to deal with stressful circumstances and to "relax." Occasional use can progress to problem use as tolerance develops and the user is prevented from finding true solutions to his or her worries. As a result, these individuals often find their problems are getting worse, and may start drinking even more to avoid their discomfort. The use of substances to relax is a deceptive illusion as it usually makes rest more difficult, is not conducive to proper exercise, and often replaces other types of recreational activity. For those who choose to drink, it is important to monitor use and make certain that alcohol is not used in a destructive manner.

These are a few suggestions that may help you avoid developing a mental health problem in a very stressful work situation. One of the greatest enemies of the correctional officer, and one of the most difficult to avoid is cynicism. It sometimes can be discouraging to confront persons on a daily basis who may be destructive or angry. You may witness a great number of traumatic events or acts of cruelty. It is easy to forget that this does not mean that all people in prison are damaged and unsalvageable. It is important to maintain a positive perspective on your role and not to give up on trying to make a difference in the lives of the persons you work with who can benefit from your efforts and interest. If you can do that, you have a much greater chance of enjoying your work and avoiding mental health problems.

The Inmate's Perspective: Walking in Someone Else's Shoes 11

Through the first ten chapters of this book, you have learned a little bit about mental illness and what we can do about it. At the end of Chapter 9, we discussed briefly the psychotherapeutic role of the correctional officer. As we discussed in that chapter, as a correctional officer, there is a line that must be drawn and you will not always be able to play the role of a sympathetic listener.

As you know, many of the inmates that you will be responsible for are people who have suffered from a severe mental illness and who have spent time in the prison system because of behavior related to that illness. It should not be surprising to you that these inmates may have some very strong feelings about the things that happened to them while in that system, and about the people who have had power over them. Some of the reactions they have to you may be upsetting or seem unfair, so it is important to understand that these reactions are the products of the way the inmate experiences events as they happen. Those experiences may have little to do with reality in some cases. As you do your job, it often will be important to recognize that everyone has his or her own experience of events and, in many cases, that experience is much different for one individual than another. The better you become at understanding how others' experiences differ from your own, the better you will be at anticipating and managing their behavior. In this chapter, we will consider some of the issues that you may encounter when working with inmates who suffer from mental illness.

Persons who suffer from mental illness often have encountered various forms of prejudice in their lives, and it is not uncommon that they have been victims of mistreatment and abuse. This may be especially true for those people you encounter in the correctional system who have mental disorders. As a result of the anguish and pain they have experienced, many persons who suffer

from serious mental illness have a very difficult time trusting others and often view their current experiences through a lens that makes them appear very much the same as some of those negative experiences in their past. It will not be uncommon for these inmates to approach you with distrust and in some cases even hostility. Your initial response to these early encounters may set the tone for all your future interactions with the inmate, so it is important to know to what you may be reacting.

Mental illness often is not understood by those who have not experienced it, and as a result, it is the source of fear and anxiety to many people who encounter it. Families are often baffled and do not know what to make of it when a family member develops symptoms of mental illness. Some try to deny its existence, others feel that the odd behavior they witness is due to laziness or weakness. When family members are unable to recognize the problem for what it is, a person with mental illness may be shut off from a very important source of support.

It is not difficult to understand why families and friends find it hard to deal with mental illness, hoping perhaps, that it will go away, or in other cases thinking that they are somehow to blame. The persons with mental illness may find that when they are most confused and frightened, there are few people around who they feel can understand or help. Those who do attempt to help are not always able to give the kind of help that is acceptable or they may do so in a way that takes control away from the person who is suffering. It is not uncommon for the person with mental illness to feel abused by people who may have had good intentions and wishes to do "what is best" for that person.

The feeling of being "different" and unwanted or mistreated is very common among persons with severe mental illness. It is not always easy for them to explain, but many of these inmates feel uncomfortable when surrounded by people and when they are forced to participate in a socially organized setting. Although they really may want to connect to the rest of the world, they are often incapable of making that connection. Their attempts to do so may be awkward or strange, or they simply may become withdrawn and seemingly disengaged. Wanting to be alone may be one result of their distrust of others or in some cases their belief that anything they share may be used against them. In some cases, suspiciousness is not due to paranoia, but rather to real life experiences.

Anger is another frequent product of mental illness, and angry persons may not be able to interact easily with the rest of the world. Young people with mental illness are often alone and frightened while others their age seem to be having a wonderful time on the threshold of life. As they grow older and find their options more and more limited, they may feel as if they had been robbed or cheated out of the years of their youth and opportunities. This disappointment is not easily shaken off, and it can take many years and many unpleasant

experiences before they are able to find ways to overcome their disabilities and find meaning and pleasure in their life. These angry feelings may be expressed in a variety of ways, and they often are touched off by events that may seem trivial when not seen in the in the light of these earlier underlying sources of anger.

The management of aggression and hostility is one of the most common and stressful situations that the correctional officer will encounter. The most natural response to provocation usually is the least effective one. That is, when we are aggressively challenged, we tend to try to gain control of the situation by responding in kind—by being forceful and aggressive ourselves. This usually only makes the situation worse and ultimately may lead to unnecessary violence. Whenever possible, if confronted by aggressive behavior, control can be accomplished best by remaining calm and quiet and gently requesting that the inmate follow instructions and think about what he or she is doing. Giving the inmate some space until he or she has regained some control is usually a good idea when it is an option. It is best to avoid any aggressive or threatening responses, even when a controlled approach fails to give results, until you have plenty of backup and can remove the aggressive inmate to a safe and contained area.

The ability to follow these simple guidelines often will make the difference between injury and a successful resolution of the problem. Of course, there will be times when you will need to use your judgment to determine that force is necessary, but in general, the less often force is used, the less tense the environment will be and the fewer episodes of violence that will occur. On this issue, you may wish to read *Conflict Management and Conflict Resolution in Corrections* by Thomas F. Christian, Ph.D., which is available from the American Correctional Association.

This anger may be particularly deep in persons who are members of a minority group. As we have seen, having a mental illness is difficult and humiliating for almost anyone in our society. When people with mental illness face the additional obstacles imposed by their race or ethic identity, their sense of separation and suspicion may be magnified. It is natural for inmates to be drawn into alliances with others who share some aspect of their appearance or experience as they seek some form of security in what appears to be a hostile place. As we noted earlier, this is more difficult for the person with severe mental illness and they are often left feeling insecure and frightened of the hostility they may encounter. Most minority groups have felt the sting of racism or other forms of prejudice while in society, and they may feel that there is little chance of escaping it in a system that is mostly controlled by people who are not like them and who do not like them. For persons who have experienced discrimination, it is difficult to expect that it will not occur again.

Racism and prejudice usually have much more to do with power and authority and the fear of losing it than the characteristics of the persecuted group. Jails and prisons are all about control, discipline, and authority for the inmate, and often for others in the system, as well. It is no wonder that they are places where racial division and bigotry may be magnified. Often, those who are most persistent and aggressive in their hatred are the persons who are most frightened and unsure of themselves. You will encounter some colleagues who have not been able to shed their own prejudices, and will probably become aware of how this impairs their ability to do their job. You will also be confronted with stereotyped thinking about your behavior, whether or not it accurately reflects your actual feeling or motives. There is little point in trying to deny or explain your actions. The only way to overcome these stereotypes is through fair, consistent, and respectful treatment of everyone in your charge.

Many of the inmates who you will encounter who have a mental illness, will have had past experiences in other institutions. Their experiences in those institutions usually came at times in their lives when they suffered a great deal and when they were frightened and confused. It is not unusual for them to feel that the institutions with which they have been associated were either unresponsive or destructive. It is difficult to have pleasant memories of a place you lived when you suffered your greatest anguish. It is important to understand that whatever the intention or result of treatments administered, when they are offered in an atmosphere of fear or coercion, they often are experienced as deeply humiliating and cruel. The loss of freedom and choice is often seen as a deprivation of dignity. Many persons with mental illness experience this loss at some time during their treatment career, whether or not they are treated in the corrections system, and it is the source of a great deal of bitterness, anger, and resentment. There are many who feel that their experience in mental health system as a form of torture. They describe their experience as a traumatic ordeal that they survived rather than as a healing process.

For those who have had several similar experiences of this kind, all institutions may begin to appear to be the same. The result is that they are likely to view the institution of their confinement as being harsh and cruel before they have any actual experiences there. In some cases, this suspicion creates a self-fulfilling prophecy. Although it may be difficult to overcome these preconceptions, sometimes the most important thing that can be offered to individuals who suffer from a mental illness is a simple offer to listen, to understand their experience, and to accept them as fully human. When this is done consistently, they gradually may be able to change their perception of their environment and adapt more constructive patterns of behavior.

How are inmates with mental illness likely to view correctional officers? When we think about some of the issues that we just considered, many view

correctional officers as authority figures and agents of control. As a correctional officer, you may be the victim of stereotypes that have been formed from past experiences. They may see you as cruel, exploitive, or hypercritical before they have any interaction with you. They may resent your freedom and power, and envy what they imagine to be your good fortune and comfort. They may believe that you enjoy their suffering. While it is unlikely that even the most incapable or sadistic correctional officer could fulfill these negative expectations in reality, they may be generalized and persistent in inmates with severe mental illnesses. These persons can interpret a variety of well-intentioned behaviors in ways that support their beliefs. While these types of expectations and perceptions are not necessarily going to be encountered in most persons with mental illness, in some cases you will encounter hostility or suspicion that has little to do with who you actually are or what you do.

Despite this, we should not deny that there are correctional officers in some systems who are not well suited for this important work. In the past, correctional officers often were poorly trained and poorly paid. They were often ill equipped to handle many of the situations and behaviors they would encounter routinely. This may be true in some cases even today, and may result in substandard treatment of these very vulnerable inmates. When this is the case, already suspicious inmates may become more convinced that all correctional officers will treat them in this way. Clearly this can create a more dangerous environment, and points out the importance of encouraging your fellow officers to get help when they are not functioning well on the job.

In summary, for the person who is confined and oppressed, the events during which they have been subjected to insensitive or cruel treatment often are remembered most clearly. It is important to recognize that we all are affected by our past experiences. Out past experiences influence our expectations and the way we experience current events. If our relationship with our parents was one in which there was cruel treatment or neglect, it is likely that we would experience others who have control over us or who represent authority in much the same way.

Many persons who have mental illnesses have been mistreated at some time in their lives, often in institutional settings, and these experiences may play a large role in how they experience you in your role as a correctional officer. An important thing to remember here is that the contempt or anger that you may find directed toward you may have little to do with your own behavior. That understanding can help you to avoid taking these expressions personally. The danger of taking things personally is that it often leads you to feel compelled to react in kind, which only makes matters worse, and may actually confirm the inmates' negative expectation about who you are and what your motivations are.

While your kindness can be a healing force, it will not always be recognized, and even when it is, its impact may not be realized for many years. The prison setting is not one in which kindness is likely to thrive, but the importance of this simple idea cannot be overemphasized as you begin a career as a corrections officer. Any kindness that you can offer will make a difference in the lives of your charges, in the safety of the institution, and in the quality of the work you do.

As we close this book, there is much that we have discussed, and much that remains to be learned. The work of the corrections officer is complex and difficult. In many ways, you will be called upon to provide counsel and comfort. Only part of the skills you will need can be suggested in a book like this. The rest you will need to develop from experience. As we have seen, the qualities that make a good officer are similar to the qualities that make a good parent. Kindness and caring are obviously a big part of the formula, but these must be balanced by firmness and consistency. We wish you every success on the journey that lies ahead of you.

Suggested Further Readings

Affective Disorders

Babior, S. and C. Goldman. 1996. *Overcoming Panic, Anxiety and Phobias*. Duluth, Minnesota: Pfeifer-Hamilton Press.

Beck, A. 1967. *Depression: Causes and Treatment*. Philadelphia, Pennsylvania: University of Pennsylvania Press.

Carter, L. and F. Minirth. 1995. *Freedom From Depression Workbook*. Nashville, Tennessee: Thomas Nelson Publishers.

Gold, M. 1989. *The Good News About Panic Anxiety and Phobias*. New York: Bantam.

Rowe, D. 1996. *Depression: The Way Out of Your Prison, 2nd Edition*. London: Routledge Press.

Psychosis

Bernheim, K. and R. Levine. 1979. *Schizophrenia: Symptoms, Causes, Treatment*. New York: Morton Press.

Keefe, R. and P. Harvey. 1994. *Understanding Schizophrenia*. New York: Free Press.

Torrey, F., E. Bowler, and I. Taylor. 1994. *Schizophrenia and Manic Depressive Disorder*. New York: Basic Books.

Watkins, J. 1996. *Living with Schizophrenia*. Melbourne, Australia: Hill of Content.

Substance Use Disorders

Alcoholics Anonymous. 1953. *Twelve Steps and Twelve Traditions*. New York: Alcoholics Anonymous World Services, Inc.

Beattie, Melody. 1989. *Beyond Codependency and Getting Better All the Time*. Center City, Minnesota: Hazelden Press.

Chiauzzi, E. J. 1991. *Preventing Relapse in the Addictions: A Biopsychosocial Approach*. New York: Pergamon Press.

Daley, D. C. 1988. *Surviving Addiction: A Guide for Alcoholics, Drug Addicts, and Their Families*. New York: Gardner Press Trade Book Company, Inc.

Daley, D. C., H. Moss, and F. Campbell. 1987. *Dual Disorders: Counseling Clients with Chemical Dependency and Mental Illness*. Center City, Minnesota: Hazelden Press.

Elkin, M. 1984. *Families Under the Influence*. New York: Norton Publishers.

Evans, K. and J. Sullivan. 1990. *Dual Diagnosis*. New York: Guilford Press.

Goldstein, A. 1994. *Addiction: From Biology to Drug Policy*. New York: Freeman Press.

Gorski, T. 1989. *Understanding the Twelve Steps*. New York: Simon and Schuster.

Gorski, T. and M. Miller. 1996. *Staying Sober: A Guide for Relapse Prevention*. Independence, Missouri: Herald House Independent Press.

Hazelden Foundation. 1987. *The Dual Disorders Recovery Book*. Center City, Minnesota: Hazelden Press.

Mooney, A., A. Eisenberg, and H. Eisenberg. 1992. *The Recovery Book*. New York: Workman Publishing.

O'Keefe, Rip. 1980. *Sober Living Workbook*. Center City, Minnesota: Hazelden Press.

Potter-Efron, R. 1989. *Shame, Guilt and Alcoholism*. New York: Haworth Press.

Read, Edward M. 1996. *Partners in Change: The 12-Step Referral Handbook for Probation, Parole, and Community Corrections*. Lanham, Maryland: American Correctional Association and Hazelden Foundation.

Tyler, A. 1986. *Street Drugs*. London: Hodder and Staughton.

Violence and Aggression

Berkowitz, L. 1993. *Aggression: Its Causes, Consequences and Control*. New York: McGraw Hill.

Bilodeau, Lorraine. 1992. *The Anger Workbook*. Center City, Minnesota: Hazelden Press.

Monahan, J. and H. J. Steadman. 1994. *Violence and Mental Disorder: Developments in Risk Assessment*. Chicago: The University of Chicago Press.

Oldham, J., E. Hollander, and A. Skodol. 1996. *Impulsivity and Compulsivity*. Washington, D.C.: American Psychiatric Press, Inc.

Roth, L. 1987. *Clinical Treatment of the Violent Person*. New York: Guilford Press.

Stone, M. 1993. *Abnormalities of Personality—Within and Beyond the Realm of Treatment*. New York: Norton Publishers.

Stress

Cornelius, Gary. 1994. *Stressed Out! Strategies for Living and Working in Corrections*. Lanham, Maryland: American Correctional Association.

Davidson, J. 1997. *The Complete Idiot's Guide to Managing Stress*. New York: Alpha Books.

Hewitt, J. 1994. *Teach Yourself Relaxation*. Chicago: NTC Publishing Group.

Lazarus, R. S. and S. Folkman. 1984. *Stress, Appraisal, and Coping*. New York: Springer Publishing Company.

Mason, L. 1985. *Guide to Stress Reduction*. Berkeley, California: Celestial Arts.

McMahon, S. 1996. *Coping with Life's Stressors*. New York: Dell Publishers.

Miller, L., A. Smith, and L. Rothstein. 1993. *The Stress Solution*. New York: Pocket Books.

Treatment

Acosta, F., J. Yamamoto, and L. A. Evans. 1982. *Effective Psychotherapy for Low-income and Minority Patients*. New York: Plenum Press.

Beck, A., A. Rush, B. Shaw, and G. Emery. 1969. *Cognitive Therapy of Depression*. New York: Guilford Press.

Cumming, G. and M. Buell. 1997. *Supervision of the Sex Offender*. Safer Society Press. Available from the American Correctional Association. Lanham, Maryland.

Harris, G. 1995. *Overcoming Resistance: Success in Counseling Men*. Lanham, Maryland: American Correctional Association.

Faiver, Kenneth. 1998. *Health Care Management Issues in Corrections*. Lanham, Maryland: American Correctional Association.

Kaplan, H. I. and B. J. Sadock. 1993. *Pocket Handbook of Psychiatric Drug Treatment*. Baltimore, Maryland: Williams and Wilkins.

Katz, L. J. 1992. *Psychiatric Rehabilitation: A Handbook for Practitioners*. St Louis, Missouri: Warren H. Green, Inc.

Klerman, G. L., M. M. Weissman, B. J. Rounsaville, and E. S. Chevron. 1984. *Interpersonal Psychotherapy of Depression*. New York: Basic Books.

Lewis, J., R. Dana, and G. Blevins. 1994. *Substance Abuse Counseling, 2nd Edition*. Pacific Grove, California: Brooks-Cole Publishing.

Nugent, F. 1990. *An Introduction to the Profession of Counseling, 2nd Edition*. New York: Merril Publishing.

Okun, B. 1997. *Effective Helping: Interviewing and Counseling Techniques, 5th Edition*. Pacific Grove, California: Brooks-Cole Publishing.

Pita, D. 1992. *Addictions Counseling*. New York: Crossroad Publishing Co.

Schatzberg, A. F. and C. B. Nemeroff. 1995. *Textbook of Psychopharmacology*. Washington, D.C.: American Psychiatric Press, Inc.

Watts, F. N., and D. H. Bennett. 1992. *Theory and Practice of Psychiatric Rehabilitation*. New York: Plenum Press.

Social and Correctional Issues

American Correctional Association. 1999. *Suicide Prevention in Custody Course*. Lanham, Maryland: American Correctional Association.

———. 1999. *Supervising Inmates with Mental Health Issues Video*. Lanham, Maryland: American Correctional Association.

———. 1999. *Supervising Juveniles with Mental Health Issues Video*. Lanham, Maryland: American Correctional Association.

Christian, Thomas F. *Conflict Management and Conflict Resolution in Corrections*. 1999. Lanham, Maryland. American Correctional Association.

Currie, Elliott. 1993. *Reckoning*. New York: Hill and Wang.

Eysenck, H. J. and G. H. Gudjonsson. 1989. *The Causes and Cures of Criminality*. New York: Plenum Press.

Faiver, K. 1998. *Health Care Management Issues in Corrections*. Lanham, Maryland: American Correctional Association.

Feldman, Philip. 1993. *The Psychology of Crime*. New York: Cambridge University Press.

Grier, W. H. and P. M. Cobbs. 1968. *Black Rage*. New York: Basic Books.

Halleck, S. L. 1987. *The Mentally Disordered Offender*. Washington, D.C.: American Psychiatric Press, Inc.

Latessa, E., editor. 1999. *Strategic Solutions: The International Community Corrections Association Examines Substance Abuse*. Lanham, Maryland: American Correctional Association.

McCarthy D. 1985. Mentally Ill and Mentally Retarded Offenders in Corrections: A Report of National Survey. In *Sourcebook on the Mentally Disordered Prisoner*. Washington, D.C.: National Institute of Corrections.

Rosner, R. and R. B. Harmon. 1989. *Correctional Psychiatry*. New York: Plenum Press.

Steadman, H., D. W. McCarty, and J. P. Morrissey. 1989. *The Mentally Ill in Jail*. New York: Guilford Press.

Schutt, R. K. and G. R. Garrett. 1992. *Responding to the Homeless: Policy and Practice*. New York: Plenum Press.

Walsh, Anthony. 1997. *Correctional Assessment, Casework, and Counseling*. Lanham, Maryland: American Correctional Association.

Willie, C. V., P. P. Rieker, B. M. Kramer, and B. S. Brown. 1995. *Mental Health, Racism, and Sexism*. Pittsburgh, Pennsylvania: University of Pittsburgh Press.

Appendix

Table A-1: Common Antipsychotic Medications

Generic Name	Trade Name	Potency	Usual Dosage (Mg/day)	Major Side Effects
Chlorpromazine	Thorazine	Low	300-1000	Sedation, dryness, dizziness, constipation, nausea, blurred vision, urinary retention, weight gain, impotence
Thioridazine	Mellaril	Low	200-700	
Mesoridazine	Serentil	Low	100-300	
Clozapine	Clozaril	Low	100-900	Can cause severe blood disease if not closely watched
Perphenazine	Trilafon	Med	52-64	Combination of side effects related to high and low potency medications, usually milder
Loxapine	Loxitane	Med	40-80	
Trifluoperazine	Stelazine	High	10-40	Stiffness, restlessness, muscle spasms, drooling, tremor, involuntary movement, weight gain, impotence
Fluphenazine	Prolixin	High	5-20	
Thiothixene	Navane	High	10-40	
Haloperidol	Haldol	High	5-20	
Risperidone	Risperdal	High	2-8	Fewer muscular effects than other high potency
Olanzapine	Zyprexa	High	5-20	

Table A-2: Common Antianxiety Medications

Generic Name	Trade Name	Potency	Common Equivalent Dosage (Mg/day)	Major Main Use
Benzodiazepines				
Chlordiazepoxide	Librium	Low	25-100	Anxiety
Oxazepam	Serax	Low	30-120	Anxiety
Prazepam	Centrax	Low	20-80	Anxiety
Temazepam	Restoril	Med	15-30	Insomnia
Flurazapam	Dalmane	Med	15-30	Insomnia
Diazepam	Valium	Med	5-40	Anxiety, Insomnia
Alprazolam	Xanax	High	0.5-6	Anxiety, Panic
Lorazepam	Ativan	High	1-10	Anxiety
Clonazepam	Klonopin	High	0.5-10	Anxiety, Panic
Other				
Buspirone	Buspar	Med	15-30	General anxiety
Propranolol	Inderal	Med	10-40	Phobia, Tremor
Clomipramine	Anafranil	Low	150-250	Obsessions and compulsions
Fluvoxzmine	Luvox	Low	100-300	
Antidepressant Medications	See table 3	N/A	Variable	General anxiety, Panic, Obsessions and Compulsions

Table A-3: Common Antidepressant Medications

Generic Name	Trade Name	Usual Dosage (Mg/day)	Major Side Effects
Tricylics			
Imipramine	Tofranil	150-300	Dizziness, sweating, dryness, constipation, nausea, urinary retention, blurry vision, sedation, impotence, weight gain, irregular heartbeat
Amitriptyline	Elavil	150-300	
Desipramine	Norpramine	150-300	
Doxepin	Sinequan	150-300	
Tetracyclic			
Trazadone	Desyrel	300-450	Sedation, nausea, weight gain— other effects same as tricyclics but much milder; no heart effects
Nefazodone	Serzone	300-600	
Serotonin Agents			
Fluoxetine	Prozac	20	Nausea, headache, restlessness, sexual dysfunction, insomnia
Sertraline	Zoloft	50-100	
Paroxetine	Paxil	20	
Other			
Bupropion	Wellbutrin	300-450	Headache, nausea, insomnia, restlessness, seizures
Venlafaxine	Efflexor	75-300	As above, plus increased blood pressure, anxiety
Mirtazapine	Remeron	15-45	Sedation, dizziness, weight gain, dryness

Table A-4: Common Mood-stabilizing Medications

Generic Name	Trade Name	Usual Dosage (Mg/day)	Major Side Effects
Lithium Carbonate	Lithobid, Eskalith	900-1500	Sedation, nausea, diarrhea, tremor, fatigue, weight gain, frequent urination, thirst, mental slowing
Carbamazepine	Tegretol	600-1400	Sedation, dizziness, weight gain, rash, nepatitis, blood disturbances
Valproic Acid	Depakote	1000-1500	Nausea, sedation, headache, tremor, hepatitis
Clonazepam	Klonopin	3-9	Sedation
Verapamil	Calan, Isoptin	240-360	Low blood pressure, slowed heart rate, constipation, nausea, dizziness, headache, fatigue

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Dr. Thompson currently is working in a satellite clinic of the Institute for Public Health and Psychiatry located in the Hill District, an economically distressed, predominately African-American community. Among the many sites where he has worked with persons with severe mental illness, the Rikers Island Prison Mental Health Service of Montefiore Medical Center has been one of the most influential. His experience working there provided a unique perspective on persons with mental illness and the institutions which house and/or treat them.

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"This book will be a godsend to correctional officers in jails or prisons who wish to understand mental illness and respond to it with kindness. It describes very sophisticated ideas in a stunningly readable fashion. Yet, despite its simplicity, the book neither undershoots its audience nor sacrifices accuracy. Clearly, these authors respect their subject, their audience and their clients."

Joel A. Dvoskin, Ph.D.
Former Acting Commissioner
New York State Office of Mental Health

"State and local correctional agencies are struggling to effectively deal with a growing number of mentally ill inmates. Line staff, primarily correctional officers, are the key to effective mental health programs in a prison or jail environment. This book provides a comprehensive yet understandable overview of the nature of mental illness, its causation, and potential treatment interventions. It will be a valuable tool for all correctional staff in establishing a common base of understanding for what so often is perceived as a mysterious problem.

This book has the potential to become a standard reference for both the pre-service and in-service training of line correctional staff. This type of publication is long overdue in the correctional setting and ACA is once again demonstrating its leadership in the field by sponsoring the publication of such a potentially useful work."

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